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ABSTRACT

This course, one of 16 sequential courses comprising phase one of a part-time Bachelor of Arts degree program in Australian Studies, discusses the conditions, mechanisms, and functions that characterize classificatory systems, taking as an example the 19th century classification of some types of behavior as madness. It is designed for independent study combined with tutorial sessions. Chapter 1 is an introduction to the course and its study objectives. Chapter 2, "All the Things That Count as Classifications," deals with the problems of classification systems. Chapter 3, "Two Types of Reasoning about Madness," discusses the history of thinking about mental disorders. Chapter 4, "From Madness to Mental Illness," discusses changes in the institutions and structures dealing with the mentally ill. Chapter 5, "The Asylum: Cure by Classification," discusses institutionalization and medical control. The conclusion discusses the effects of classification. Two tutorials are also included, one dealing with the process of classification, the other with classification and mental illness. Also included are lists of required readings, additional readings, a bibliography, and self-assessment questions. (IS)

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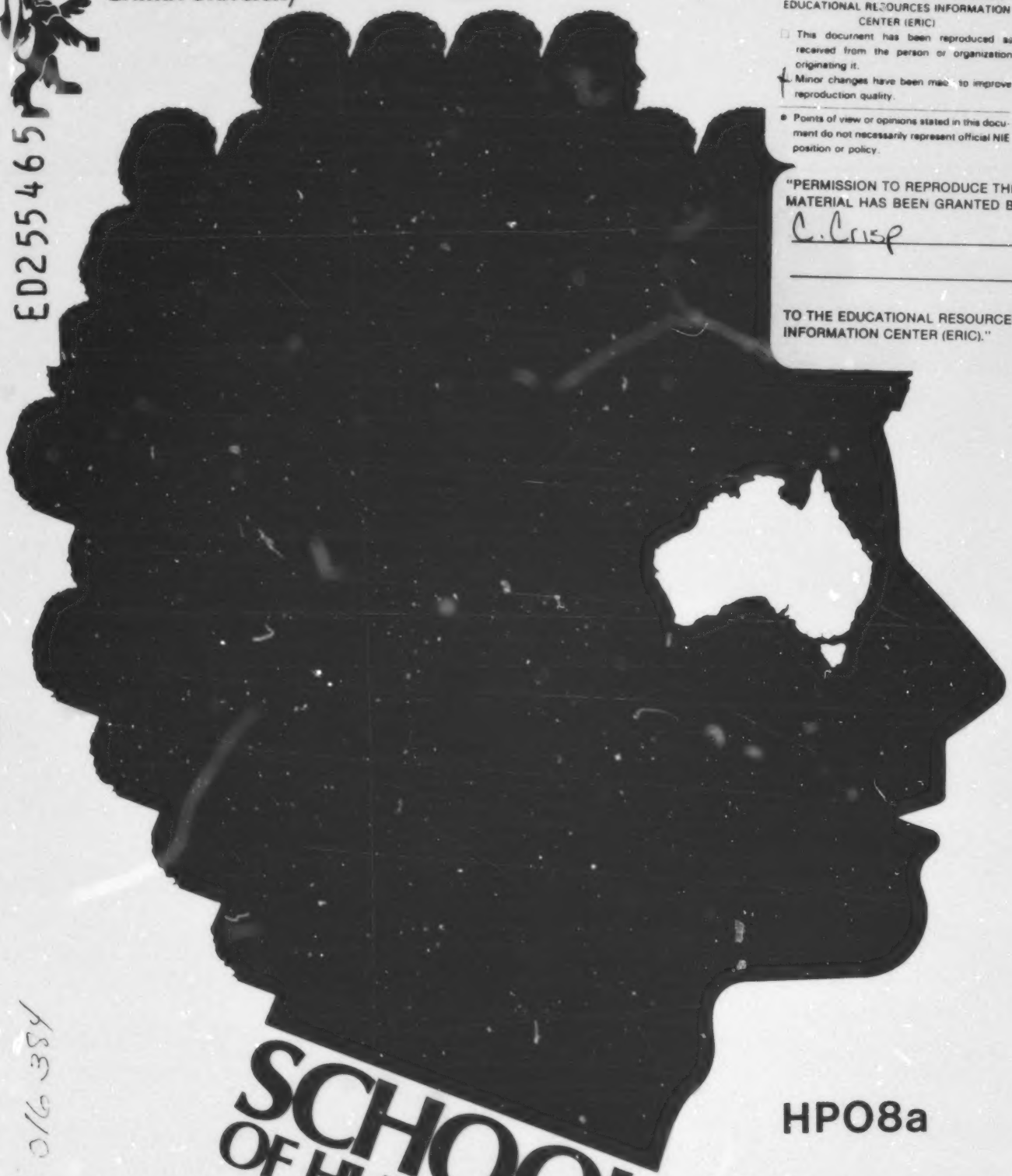

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PART TIME BA DEGREE

GRIFFITH UNIVERSITY
SCHOOL OF HUMANITIES

PART-TIME BA DEGREE PROGRAMME

COURSE HP08a

CLASSIFICATIONS

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Course Readings

In this course you are required to own one book, which is available from the University Bookshop:

Paul Hirst and Penny Woolley, *Social Relations and Human Attributes*, (Tavistock, 1982) ($14.95)

You will have already purchased this book for Course HP03b, *Authorship*, and we will make extensive use of part II - Mental Illness and Personality - in sections 3, 4 and 5 of the course. However, the book is also of interest for its treatment of a number of debates in the human and social sciences and so makes a good general text to have at your disposal in Phases 2 and 3 of the programme.

There are fifteen additional readings that the study guide takes you through. These are grouped and listed under each of four main sections of the course. The bibliography at the end of the study guide provides further details on each of these readings should you wish to consult the texts from which they are taken. In addition, there is a list of further readings, indexed by section, for those of you with the time and interest to follow up particular themes or problems in more detail.

Tutorial Activities

There are two optional tutorials which are designed to be helpful, although not essential, for the completion of the assessment item. You should complete the preparatory work for the tutorials whether you attend them or not.

The first tutorial, at the end of section 2 (p.34), reinforces the difference between the main theoretical perspectives on classification. The second tutorial, coming at the end of section 5 (p.83), discusses the form taken by psychiatric classification at the beginning of the nineteenth century. Tutorial Two also reviews the course in relation to the assessment item in that it compares nineteenth-century psychiatric classification with the general picture of classification described at the beginning of the course.

Assessment

The assessment for this course is in two parts. The first part consists of a short exercise in which you are asked to identify two descriptions of insanity, saying whether they were written before or after the major classificatory shift studied in the course. This is the transition discussed in sections 3, 4 and 5 of the study guide. The second part takes the form of an essay in which you are

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asked to demonstrate your grasp of the major theoretical and historical approaches to classification discussed in the course.

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LIST OF READINGS

Readings are numbered in order or use, and aggregated according to the section of the study guide in which they first appear.

Section 2 (pink cover)

Reading 1. Carl Hempel, 'Fundamentals of taxonomy' (excerpts)

Reading 2. Pierre Bourdieu, 'The Berber house' (excerpts)

Reading 3. J. Newsome ed., *Pliny's Natural History* (excerpts) (for Tutorial One)

Section 3 (cream cover)

Reading 4. Michael Donnelly, 'Perceptions of lunacy in early nineteenth-century Britain' (excerpts)

Reading 5. Michael Donnelly, 'Perceptions of lunacy in early nineteenth-century Britain' (excerpt)

Reading 6. Gregory Zilboorg and George Henry, *A History of Medical Psychology* (excerpts)

Reading 7. Thomas Szasz, 'The myth of mental illness' (excerpt)

Reading 8. Andrew Scull, *Museums of Madness* (excerpts)

Reading 9. Robert Collis, 'Physical health and psychiatric disorder in Nigeria' (excerpt)

Section 4 (yellow cover)

Reading 10. Jerome Gaub, *De Regimine Mentis* (excerpts)

Reading 11. Michel Foucault, *Mental Illness and Psychology* (excerpt)

Reading 12. Michel Foucault, *Madness and Civilization* (excerpts)

Section 5 (blue cover)

Reading 13. Samuel Tuke, *Description of the Retreat* (excerpts)

Reading 14. Philippe Pinel, *A Treatise or Insanity* (excerpt)

Reading 15. Michel Foucault, *Madness and Civilization* (excerpt)

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Assessment Item

Reading 16.

Reading 17.

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PRELIMINARY EXERCISE

The following list of classes of birds shows you some of the classes recognised and used by the Kalam, a tribal people living in the highlands of New Guinea. The list was composed by a member of the Kalam in collaboration with a Western anthropologist.

A. Birds that feed at flowering trees.

B. Birds in which women show themselves (i.e., that represent women in dream experience).

C. The families of birds that come to places where there are stones that they can break up small and swallow.

D. Birds of the inner foliage.

E. When this bird comes, we say that the season of the sun has arrived.

F. Those kinds of birds that constitute the family which vomits up the food that they have eaten. (The bats.)

G. The Yellow and the Red Birds of Paradise are birds that are different from all others.

H. The kinds of birds that just fly constantly around.

I. Birds which men's souls can turn into (i.e., that represent men in dream experience).

J. Those birds that perch high in the lopped trees.

K. Birds that fly above water.

L. Birds of Darkness.

M. The families of birds which take furred animals, birds, snakes, lizards and carrion.

N. The Cassowary. (Not normally considered to be a 'bird'.)

1. Go through the list and try to allocate each item under one of the following headings:

Classes that resemble Western classifications of birds and animals	Classes that do not resemble Western classifications	Hard to tell

2. Now go through the lists and consider for each class why you decided it resembled or differed from the Western classification of birds.

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3. For each of the different classes, see if you can think of the associated surrounding cultural activities or practices (distinguishing the seasons or different locations, magic, hunting etc.) that set them apart from our categorisations. Note these down.

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1 INTRODUCTION TO THE COURSE AND ITS STUDY OBJECTIVES

In this course we have set ourselves a task which probably calls for some initial justification, namely, the investigation of the particular set of human activities that give rise to *Classifications*. The justification of such an investigation requires, at the very least, a clear statement of why the activities that produce classifications - we can use the general term classificatory practices to name them - are taken to be interesting or important enough to merit your attention at this point in the programme.

In isolation, the term classification sounds all too abstract. In practice, however, classifications that have established themselves within a given culture or society have significant cultural or social effects. This is seen in the brief mention of the Kalam classificatory practice for differentiating between classes of birds. In this example, these effects include the organisation of time and work, and the determination of appropriate conditions for magical activities.

But there is, of course, much more to classificatory practices than drawing distinctions between types of bird. You will know from your own educational experience that schools, colleges and universities are organised according to certain (and different) classifications of knowledges into disciplines, taught in different departments and by different teachers. Both teachers and students can, in fact, categorise themselves according to this classification, by referring to a particular subject or class of knowledge: I'm a physicist; you're a geologist; she's a mathematician. Similarly, in earlier courses in this programme, you will have encountered questions concerning classifications and classificatory practices. In Course HP03a, *Community and Identity*, communities were classified depending on whether they are local or dispersed, consensual or non-consensual. These categories were arranged as a grid providing four possible classificatory positions for any given community. (Note, however, that one classification was empty - dispersed coercive communities did not appear to exist.) The classificatory grid here was being used as a means of organising the study of communities.

On the other hand, you have also looked at classifications as topics for study in their own right. In Course HP01b, *Traditions*, you explored the way in which various cultures establish boundaries and classifications for people, events and natural objects, separating the married from the unmarried, the child from the adult and so on. Similarly, in Course HP07a, *Penal Colony 1*, you looked at the way in which Australia's early penal institutions classified criminal types and behaviour.

In other words, you have already come across classifications playing two different roles: (1) as a means of

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describing the world; (2) as cultural or historical phenomena to be studied in their own right. This course offers the opportunity to reflect on both of these orientations which are present in the central question:

> *What is it that we do when we classify people, events, things etc.?*

We should make it clear at the outset that our approach to this question will be descriptive. This means that the course will simply describe whatever it is that counts as a classification or a knowledge in a given culture or historical period without deciding whether this corresponds to some 'truth' about the world. To clarify this point, you will be introduced to three major approaches to classification:

1. The first approach, in contrast to the one we take in the course, involves itself with the issue of judging the truth of a classification by deciding whether or not it corresponds to some universal norm of validity or correct knowledge. This approach is usually described as 'scientific' in our society. It attempts to assess classificatory schema in relation to what is seen as correct knowledge. It develops certain practices (e.g. of model-building and hypothesis-testing) to assess whether a classification is true or false. In this course, we will call this approach normative because it relates classifications and classificatory practices to what are seen as universal norms for distinguishing correct from incorrect knowledge.

   You can get some sense of the normative approach by asking yourself whether it is possible to judge the degree of correspondence between the Kalam classifications of birds and the way birds really are in nature. Even if you decide, on the basis of your knowledge and your cultural belief in the existence of universal norms of validity, that the Kalam classification is incorrect knowledge, the problem remains of explaining the evident adequacy of this classification for the Kalam themselves and their culture.

2. The Kalam example is drawn from an anthropological study. Anthropology (and sociology), unlike the normative approach, are frameworks capable of offering a non-normative approach to classification. For example, Arnold Van Gennep, David Pocock and Pierre Bourdieu whose work you looked at in Course HP01b, *Traditions*, describe classification of people into married and unmarried or of artefacts into high art and popular art, simply by looking at the ritual practices and techniques that determine what counts as such in particular cultures. Bourdieu does not attempt to judge the high art/low art classification against some universal norm to discover whether it is true or not. He simply

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describes the classification itself as a cultural product. The course will, therefore, introduce anthropological and sociological frameworks in which a descriptive approach to classification is possible.

3. Historical frameworks allow both approaches: normative and descriptive. We will look at both types in this course and again in Course HP08b, *Disciplines*. They would be normative if they judge earlier or non-European classifications - like the Kalam bird classification - against a single norm of correctness located in the present Western scheme of things. This produces a scheme in which exotic knowledges are pictured as primitive anticipations of knowledge discovered in Europe in the nineteenth and twentieth centuries. For obvious reasons, such a history is sometimes called 'progressivist'.

   However, historical frameworks also allow approaches that are non-normative, when they simply describe earlier forms of classification without treating them as errors and without treating the history of classification - or indeed knowledge - as the progressive discovery of what we now call the truth.

It is worthwhile making sure that you have grasped the above distinctions:

1. between normative and descriptive approaches;

2. between historical frameworks, which can be either normative (scientific) or descriptive (sociological or anthropological).

With these distinctions established, you will be able to follow the development of the main example of classification that we look at in this course: The re-classification of madness as mental illness at the end of the eighteenth century. (Prior to this time madness had been classified as a species of bodily illness like all the rest.) As we have said, our treatment of this example will be descriptive not normative; this means that it will draw on anthropological, sociological and historical frameworks. At the same time we cannot ignore the fact that much of the history of psychiatric classification has been written using scientific or normative categories.

By tracing the emergence of psychiatric classification it is possible to show that classifications are not simply abstract exercises. The establishment of a category - the mentally ill - into which persons can then be placed has had concrete social results. You will have read about some of these in Erving Goffman's *Asylums* - e.g. the process of self-mortification. We shall further discover that psychiatric categories and techniques are widely distributed across Western social institutions; so much so that they form a perpetual backdrop against which individuals judge their own feelings and behaviour.

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As for the structure of the course, following the introduction, the work is divided into four main parts:

In section 2, we set up the problem of describing classificatory systems and demonstrate a scientific account of them; this is followed by an account that draws on a sociological and anthropological framework.

In section 3, we shall look in some detail at the different sorts of history of the reclassification of madness as mental illness that are produced by normative and descriptive approaches. At the end of this section, we introduce a framework that is neither scientific nor strictly sociological (or anthropological). The most famous modern exponent of this view is Foucault.

Section 4 permits us to develop this last framework by reconsidering the historical conditions under which mental illness could become the object of psychiatric classification, following certain changes in eighteenth-century medicine and systems of confinement.

Section 5 completes this exploration by providing materials related to the formation of the first insane asylums at the beginning of the nineteenth century.

Across these four main sections of the course, you are expected to develop a knowledge of four issues addressed here:

1. What are the features of particular classificatory practices characteristic of our own time and culture in relation to others?

2. What are the main features of the system of classifying people - or more precisely certain forms of conduct - that emerged in the late eighteenth century and which allowed for a new class of the 'mentally ill'?

3. In relation to competing explanations of the emergence of the category 'mentally ill', what are the differences between histories written in a scientific framework and those written in a sociological framework?

4. What are some implications of our investigation of classification for studies of mental illness in the humanities and social sciences?

These issues are not all developed to the same extent in the course. A considerable amount of your work, in the study guide and the readings, is devoted to one historical example - the shift in the system of classifying conduct to define 'mentally ill'. However, the focus of the course is broader than this example. In other words, for all its interest and importance, the objective of the course is not to acquaint you solely with the knowledge of the social classificatory machinery in which mental illness first

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appeared at the end of the eighteenth century. Rather, the objective is also to draw out some more general reflections on the complex set of historical and sociological effects of classifications and classificatory practices.

To get some sense of what such effects might be, our first step is to see how (without being drawn into a normative approach), the problem of describing classifications can be analysed and resolved.

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2 ALL THE THINGS THAT COUNT AS CLASSIFICATIONS

This *Indian* beast, by Nature armed so,
That scarce the Steel can pierce his scaley side:
Assaulteth oft the *Elephant* his foe,
And either doth the conqueror abide,
Or by his mighty combatant is slain,
For never vanquished, he returns again.

So you that must encounter Want, and Care,
To overcome your hard, and crabbed skill,
Take courage, and tread underfoot despair,
For better hap, attends the venturous still:
And sooner leave, your body in the place,
Than back return, unlettered with disgrace.

A Rhinoceros
was sent to Rome
by Emanuel king
of Portugal who
fought with it
coming on land
through Provence:
but by the way
by hard fortune
it was drowned
near Porta Venere:
seeking a long time
to save itself
among the Rocks.
Paulus Iovius

Henry Peacham, 1612

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2.1 Terms of reference

At its simplest, a classification is the ordering of things into different groups according to some principle of differentiation. Given that we order everything into groups - from plants and beauty contestants to examination results, athletics events and the security rating of public servants - you might expect it to be argued that classifying things is a natural human capacity or propensity. You may also think this is evident from the fact that a common set of terms can describe all these different classifications:

Classification (or Taxonomy)	
class (category)	(or genus)
sub-classes	(or species)
elements (members)	(or individuals)
common or distinctive properties	(or characteristics)

Because of this single set of terms, it looks as if there is something common to all the things we could call 'classifications'. Indeed, this 'something common' is a key component of the scientific or normative framework. We shall look briefly at this framework, then contrast it with the anthropological framework.

In the scientific framework, the assumption that there is something common to all classifications is tied to a belief in a general process whereby boundaries are drawn between different classes of things. This process derives from a supposedly universal human capacity, namely:

> the capacity to observe common properties and categorise groups of objects on this basis.

In this view, the ability to classify or categorise is taken to be a general attribute possessed by every human subject; e.g. the ability to think the concepts of 'maleness' or 'femaleness'. At the same time, certain common or distinctive characteristics are taken to be natural properties of different groups of objects; for example, the natural properties which distinguish male from female. Concept and property are then linked by the process of observation, which is pictured as a natural capacity to recognise properties and their distributions. Objects will then be put into certain classes if they are observed to have the properties that match the concept that defines the class. So, if we define the categories of male and female in terms of the possession of male or female genitalia, then all babies can be classified as male or female once either of these properties have been observed. And, indeed, this is how babies are classified in our hospital system.

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So, in the scientific framework, it looks as if our common set of terms for classification does name a single process of classification that is fundamental because it is in accordance with both the natural properties of objects and the universal capacities of individual human subjects to observe these properties and match them to certain concepts.

So much for a rapid and schematic account of classification, as conceived in a scientific framework. The important thing is to recognise the limitations of this framework. We do this by analysing other frameworks, such as the anthropological. To illustrate this, you can refer back to Course HP01b, *Traditions*, where you looked at particular classifications, such as that of certain persons as Aboriginal. In this course, classifications were seen as products of particular historical or cultural institutions (section 3 and readings 6-12 of Course HP01b, *Traditions*).

You will recall the way in which Northern Territory law classifies certain groups of Aboriginals as persons with rights to land ownership by virtue of their ritual relation to the land in question. On the one hand, this relation to the land is not an observable natural property of Aboriginals but is something produced by their particular ritual observances. On the other, 'ritual relation to the land' is not a concept that we can associate with a universal human capacity for thought. Instead, it is a specific legal instrument for defining a class of Aboriginal land owners; it arises out of the discipline of anthropology. The historical and institutional particularity of this classification is underlined by the fact that it is quite possible for someone to possess the property of a 'ritual relation to the land' (or, indeed, of 'Aboriginality') in one state of the Commonwealth but not in another where different legal conditions obtain. Similarly in Course HP01b, *Traditions*, seven methods of defining an Italian revealed the competing social and cultural categories that can be applied. Here, it is cultural institutions that provide human beings with particular procedures for categorising. Northern Territory law provides judge and jury with anthropological procedures for forming the category of Aboriginal land ownership.

This example of classification in a sociological and anthropological framework, suggests that all classifications do not derive from a single fundamental process rooted in the nature of human subjects and the objects that make up their world. Instead, we will have to examine the classificatory role of cultural institutions from case to case in order to understand what counts as 'observation', 'categorisation', and ultimately 'classification'.

In contrasting our two approaches, consider the following crucial general point: classifications establish boundaries around groups of things, events, people etc.; and it makes a great deal of difference whether these boundaries are seen as grids that accord with natural divisions (as in

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the scientific framework) or as historical grids for constructing cultural boundaries (as in the sociological and anthropological framework).

In the case of the classification of the mentally ill or insane, this is the difference between viewing insanity as a natural phenomenon set apart by certain universally observable symptoms, or viewing insanity sociologically as a historical phenomenon set apart by the operation of particular cultural institutions, like the asylum. The importance of the difference between scientific and sociological frameworks to our central example - the historical emergence of psychiatric classification - should thus be clear. It means either that the classification of the mentally ill corresponds to a natural division in any human population; or that it is used to construct a cultural boundary specific to particular societies. Hence, our comparison of scientific and sociological frameworks should enable us to come to terms with an important and controversial question in the contemporary social sciences: the question of whether the forms of behaviour that have become the objects of psychiatric classification are the natural endowment of human beings or the attributes they acquire by virtue of the social institutions they inhabit. You will remember from Course HP03a, *Community and Identity*, that Goffman constructs mental illness as socially defined, while many of you felt that some people really were mad - the scientific approach.

The answer to this question in its turn affects our understanding of the kind of goals that can be set for psychiatric classification and the type of reform to which psychiatric practice is open. If the classification of mental illness is governed by the natural properties or characteristics of the mentally ill and our universal capacities to observe and categorise these (as is maintained in the scientific framework), then psychiatric classification could claim the status of a universal science, which means basically a general explanatory theory of insanity. If, on the other hand (as is argued in the sociological framework) psychiatric classification is dependent on the formation of particular capacities to observe and categorise certain forms of behaviour (i.e., institutional capacities analogous to those provided for the judge and jury in land rights cases), then it will function as a means of establishing and maintaining a particular cultural boundary between the sane and the insane. The analysis of psychiatric classifications differs greatly between these two perspectives. The difference between the scientific and the sociological/anthropological frameworks is thus by no means purely theoretical. It has important practical social consequences and we must keep these in mind when working our way through the sometimes difficult theoretical materials that make up section 2.

We can now return to the problem of describing classifications; here, we must look in greater detail at

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both the scientific and the sociological frameworks. In section 2.2, we will examine Carl Hempel's 'Fundamentals of taxonomy'. As you might suspect from the word 'fundamental' in the title, this article represents a scientific attempt to isolate a fundamental norm or method of classification supposedly arising from the nature of subjects and objects.

2.2 Grids over nature

Simplifying somewhat, we can assume that a scientific approach suggests that there is a common method to all the things we call knowledge. This method is the scientific method and consists of observation, using the appropriate methods, by subjects or individuals, free of social contamination, of objects or the things they want to know about. If observation is scientific, it is reliable and can be repeated by another observer with the same results. This is called intersubjective agreement between observers. It means agreement between subjects or observers. Hempel also uses the notion subjective to mean prejudicial or idiosyncratic. This is because both subjective and intersubjective refer to the role of the subject observer. The observer may be both biased or free of bias depending on the method used. You may like to note the two usages of the term in the Hempel extract. Reliable observation leads to description or classification of things - whether they be rocks or mental states. This may finally lead to explanation of why these things differ from each other. The scientific method, then, rests on observation, description or classification, and explanation which displays scientific understanding of theoretical principles and general laws which allow prediction of future events.

All these ideas are taken up by Hempel in reading 1, which is quite difficult (largely because of the many unfamiliar terms it contains) but also quite short. It may help you to read it by concentrating on Hempel's use of the notion of observation and how he relates this to classification and explanation.

Hempel wishes to found all classification in a single scientific method. However, his main examples in this article are procedures for classifying people as 'mentally ill'. Hempel argues for a uniformity between the categories and methods of the natural and social sciences. Note, in the following reading, that Hempel starts with the classification of concrete 'natural' objects such as stars and crystals, moves to the taxonomic methods of biology, discussing finally accounts of physical and mental illness. He is arguing for a continuity of procedures and hence of the essence of the objects to be classified in all cases. It is only our lack of knowledge at any stage that deprives a discourse of its scientific method. All objects will eventually be open to scientific classification. This is the progressivist viewpoint mentioned briefly above. In the next course, HP08b, *Disciplines*, you will study the problems

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of constructing a discipline as a science. Here, suffice it to say that Hempel writes from a scientific discourse - a discourse that claims there is one true knowledge of objects in the world. He attempts to set up a fundamental form of classification based on the universal capacity of individuals to observe and categorise according to distinctions that are already present in the natural properties of objects.

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Read Carl Hempel, 'Fundamentals of taxonomy' (excerpts), reading 1.

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We can see in section 2 of the excerpt that classification, for Hempel, is a simple matter. Each of the classes that composes a classification is defined by a single type of relation between a concept and the group of properties or characteristics that it represents. If an object shares the properties represented by the concept then it belongs in the class specified by the concept. Whether the classification is of birds, Aboriginals, or forms of human conduct, in each case it reduces to this single definitional form.

SAQ 1

Suggest briefly why psychiatric diagnosis is a type of classification. (R1:1)

In treating classification as a relation between the ideas of individuals and the properties of objects, Hempel formulates the problem of classification by means of the following question:

> How do we know that our ideas or concepts are reliable, that is, that they represent the same groups of properties for different subjects?

Here we can see why scientific views of classification involve normative rather than descriptive approaches. The criterion for a good classificatory system becomes its ability to uniquely and reliably place objects into the appropriate class. Reliability, or the ability of other observers to repeat the classification, becomes the crucial test of the classificatory schema's value. This is the process of concept formation and clarification that Hempel outlines in section 4 of the excerpt.

In this section, Hempel describes the reliability or objectivity of concepts in terms of the uniformity with which they are applied. He specifies uniformity of

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application in terms of the intersubjective agreement between observers of the properties represented by the concept. Agreement between observers as to what they see is thus crucial for Hempel's account of classification because it is the means by which he establishes whether concepts are reliable representations of the groups of properties that define class membership. However, there is some ambiguity in Hempel's account of agreement between observers and hence in his account of the reliability of classificatory concepts. In fact, he accounts for agreement between observers in two quite different ways:

1. in terms of a set of procedures for observation by means of which individuals decide on the applicability of a term.

2. in terms of a direct observation of properties that supposedly provides an absolute test of applicability.

By equivocating between these positions Hempel is able to use two quite different conceptions of how agreement between observers is reached, without clearly distinguishing between them. Either agreement is reached because observers are trained to employ the same procedures when applying classificatory terms. Or, it is reached because the properties of objects are directly observable and all human beings possess the same capacity for observing them. Provided that this capacity is freed from distorting opinions and value judgements, observers spontaneously see the same things. The difference between these alternatives becomes strikingly apparent as soon as we reconsider the case of the legal classification of Aboriginal land ownership. We have seen that under Northern Territory law the discipline of anthropology provides the jury with procedures (based on the notion of ritual relationships to the land) for determining whether a particular person or group has such a relation to the land in question and hence whether they are to be classified as the rightful owners. But there is clearly nothing natural or universal about this state of affairs. In another state, the jury might well be provided with formal legal procedures based on the purchase of title deeds that determine land ownership. As a property possessed by those Aboriginals seeking to be classified as rightful owners, the notion of land rights would thereby change quite dramatically.

We can see here that for jury members to agree in their observation of the legal property of land rights, they must be institutionally provided with a uniform set of procedures that determine what is to count as an observation. Only then is a uniform application of classificatory terms possible. This exemplifies Hempel's first account of how observers come to agree. But what about Hempel's second account, according to which they agree because the properties of objects are directly perceivable and human observers are endowed with a universal capacity for observation which leads them naturally to see the same

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things when they look at objects. Can we imagine what it would be like to observe directly the quality of land rights possessed by Aboriginal groups? Can these be observed independently of some definite set of procedures like those provided by anthropology for determining ritual relation to the land, or those provided by the law for determining the purchase of title deeds? The answer seems, pretty clearly, to be no.

Hempel fails to take account of this difference. The reason is that he wishes to provide classifications not merely with the historical reliability that flows from the use of a set of uniform observational procedures, but with a sort of external reliability grounded in a naturally endowed capacity for observation. This absolute guarantee is necessary for Hempel's argument that all classifications reduce to a single, fundamental, scientific form. He is seeking a form able to resolve all differences between classificatory systems (like those arising from different state laws for classifying Aboriginal land rights).

On this line of argument, disagreements over categorisation can only occur when social norms, opinions and value-judgements obscure the naturally endowed capacity for observation. There can never be any real disagreement at the level of what is to count as an observation or category (e.g. disagreement between the sets of historically available observational procedures). Hence, it is the role of scientific method to strip away socially given impurities (norms, opinions, value-judgements, etc.) and leave the observer in as close to his or her natural state as possible. Training classifiers (e.g. training judge and jury in the anthropological classification of land rights claimants) is thus given the rather paradoxical role of producing a capacity that is supposedly already there as a natural endowment.

In section 4 then, Hempel confuses two quite different accounts of agreement between observers and hence of the uniform application of classificatory terms. The first account is based on the notion of training (e.g. of psychiatrists) in the use of a uniform set of observational and classificatory procedures. The second account concerns the move to strip away all social or subjective factors to allow a spontaneous common observation of natural properties (e.g. the symptoms of insanity) against which the terms of the classification can be tested. Hempel's confusion is nowhere more apparent than when he attempts to treat training as a means of achieving the goal of spontaneously agreeing on classifications.

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Re-read section 4 of Hempel, reading 1 in the light of the preceding remarks.

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SAQ 2

On R1:1-2, Hempel applies his analysis to the classification of mental illness. He does so by attempting to show how a value-laden category like 'inadequate personality' can be made reliable by stripping away social norms from the process of classification. This is to be achieved by providing classifiers with a new set of criteria for determining what is to count as a symptom; for example, a symptom of a well or poorly 'adjusted' child.

1. List the new set of criteria or 'indicators'.

2. In a few lines, suggest why you think the new criteria or 'indicators' are (or are not) just as socially determined as the ones they replace.

It seems fairly clear that in a society lacking our norms of personal grooming and social conversation many of Hempel's symptoms of personality disorder would not be observable as such. In other words, in providing the new 'indicators' Hempel is not really stripping away social norms from some more fundamental process of psychiatric observation and categorisation. Rather, he is including them in a modified set of procedures in which psychiatrists must be trained if their observations and categorisations are to agree. This clearly indicates Hempel's difficulty. Rather than be individuals totally freed of social training, he suggests that a 'certain body of common training and experience such as might be found among trained child psychologists' will be required to achieve uniformity and agreement. But he treats this as a weak spot, as a place where 'subjective factors enter into the application of a given set of concepts'; and his aim remains to reduce the need for training in common interpretive procedures in favour, presumably, of a direct observation reached by stripping away all social norms and factors.

In other words, whereas Hempel is concerned with how closely classification can approximate the goal of direct observation, we are concerned with whether it makes sense to pursue such a goal. We will see below in much greater detail that psychiatric observation and classification are inescapably bound up with social norms and practices. But this does not mean that particular social norms or

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subjective values must be seen as necessarily distorting some ideal spontaneous relation between the natural properties of objects and a universal capacity for their observation and categorisation. Rather, it is here suggested that what counts as psychiatric observation and categorisation is always determined by the social attribution of definite procedures. Sometimes these procedures for classifying certain behaviour as insane, may embody norms that define thresholds beyond which particular forms of appearance (a fixed stare) and behaviour (undressing in the main street) will be observable (i.e., will come to be recognised) as symptoms of mental illness. There can be no question of attempting to strip away these social norms from the process of observation because they are inseparable from the very procedures which define, for our culture, what counts as an observation of psychiatric symptoms. In other words, observation is always also a process of interpretation, a recognition in terms of socially given formulae.

In other words, the classificatory division between the sane and the insane is a social boundary constructed when individuals (both professionally and in private life) are trained in the use of definite procedures that determine what we now recognise as the observation and classification of symptoms of mental disorder. On the other hand, Hempel (and Gregory Zilboorg and George Henry as you will see in section 3.2 below), in approaching the problem via the question of the ideal objectivity of classificatory terms, is bound to treat classificatory divisions as boundaries that must approximate natural boundaries. Thus, when categories have been clarified by the stripping away of all social norms and procedures, classification will necessarily be a grid over nature.

At this point, we shift our attention from the question of how and whether classifications represent the natural divisions between classes of objects in the world to the question of how individuals come to be provided with classificatory capacities by the social and cultural institutions they inhabit. In other words, we must pass from the scientific approach in which classification appears as a grid over nature to a sociological approach where it is treated as an artefact or a product of culture.

2.3 Products of culture

We began our discussion by setting up an opposition between a scientific approach, which permits the discovery of natural boundaries around classes of objects, and a sociological approach, in which classifications are determined by particular historical institutions and procedures; these provide individuals with definite cultural capacities for establishing and maintaining social boundaries.

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Thus, this primary opposition between natural and social classifications involves a second opposition: this is roughly that between (a) directly observing or recognising something (e.g. the properties of the insane or the rightful owner of land); and (b) putting something into practice (e.g. employing a particular set of psychiatric procedures that determines what has come to be accepted as observing a symptom of mental illness).

Our initial distinction between natural and social classifications involves us in a further opposition between (roughly speaking) cognitive or thought processes and social practices. Hempel's scientific approach is based on the idea that classification arises from a general process of cognition (or recognition) that links ideas to objective properties. This is our 'natural' picture of classification as a process in which a subject sees or recognises the common properties of a group of objects and checks whether they fit the idea he or she has of them. But we will have to prepare ourselves to give up this familiar picture if, as seems likely, observation and categorisation are matters of particular social practices, like employing a particular institutional procedure, rather than undergoing a natural process of recognition.

Notice how this affects the problem of describing classifications. If what counts as observation and categorisation, and hence classification, changes depending on the social procedures being employed, then we cannot provide a general theory of classification as a single cognitive process. We can only describe particular social practices and our descriptions will depend on a practical familiarity with these practices. This change in orientation will have a decisive effect on the example of psychiatric classification, as we shall see below.

The move from the scientific to sociological model permits a decisive change in our approach to the problem of classification. We need no longer focus on the general relation between the properties of objects and the cognitive powers of subjects. Now we can pay attention to the particular social practices that establish and maintain classificatory boundaries, and to the cultural institutions that equip individuals for these practices. This is a move into unfamiliar territory, but one that promises a more rewarding understanding of classifications in all their variety than the well-trodden track of scientific epistemology. However, in order to make our way, we need a distinct set of terms adequate to the changed theoretical circumstances in which we now find ourselves.

We can now provide this set of terms by laying out in parallel sentences the new key words that have been accumulating during our discussion of the scientific and sociological frameworks. This is done in the box on the next page.

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In Hempel's scientific approach:	In the sociological approach:
Classification results from	Classification results from
general forms of observation and conception	particular forms of action
rooted in	governed by
natural cognitive processes	social practices and techniques
that can be discovered by	maintained by
stripping away social norms and procedures	training in cultural institutions
leaving the individual as	which define individuals as
human subject.	social agents.

The opposition between human subject and social agent provides the crucial handle with which to pick up the whole bundle of terms. Human subject refers to the notion of the individual as a thinking subject, free of social contamination and constraint. One is thought of as a subject 'to one's core', utterly. You can get the gist of the term 'social agent' by calling to mind a term like 'insurance agent' or reminding yourself of the way we call a clerk of courts an 'agent of the court'. These terms tie the individual's capacities and conduct to particular, public procedures and techniques, exercised and practised by individuals as agents of cultural institutions and social organisation. One is not an insurance agent to one's core; it is just a role or aspect of an individual. Moreover, it is a role that is organisationally defined. One acts for and on behalf of the organisation.

To explore this opposition, we will look at Pierre Bourdieu's description of the structure of the house and how it influences the life of the Berber peoples of North Africa.

Bourdieu shows how classifications and classifiers are embodied in a social artefact, the household. It is nonetheless important to see how Bourdieu uses his detailed study to mount a broad challenge to scientific accounts of classification. This he does by insisting that classificatory boundaries are determined by social institutions and practices rather than deriving from the

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mind of the individual subject. It is this broad challenge that interests us and we will retain only enough detail necessary to understand the character of Bourdieu's challenge.

In order to see what is at stake in his description of the Berber house, the following points provide you with his theoretical framework:

1. Bourdieu challenges the scientific picture that reduces classifications to purely cognitive processes. Classifications, in Bourdieu's sociological and anthropological framework, have practical functions. They are embodied not in natural, mental processes but in social activities or practices. Thus, you will see in the reading below that the classificatory divisions of male and female embodied in the house serve the practical function of dividing and organising domestic work in relation to agricultural labour.

2. The writer describes these social practices with the notion of *habitus*. 'Habitus', the Latin origin of our words 'habits' and 'habitation' (or living place), is a technical term naming our disposition or tendency to act in certain regular ways. These dispositions are acquired by definite forms of training or structural exercises contained in ritual techniques (songs, games, proverbs, etc.) and in the organisation of architectural space in particular. Thus, Bourdieu describes the way in which the organisation of the household disposes women to regularly move inwards to the private spaces of sexuality and domestic work, while men learn the disposition to leave the house for the fields and the spaces of public life.

3. Bourdieu describes the way in which educative exercises pervade living space. This is quite difficult for Western readers to understand. The Berber people possess neither the technique of writing nor a specialised educative institution like our school, yet their classificatory system is highly organised. The capacity for classification is acquired not primarily through explicit linguistic instruction but through practical exercises: things that individuals are required to do and say in different parts of the house. Bourdieu calls these 'structural exercises' and gives this analysis of them:

> Between apprenticeship through simple familiarization, in which the apprentice insensibly and unconsciously acquires the principles of the 'art' and the art of living, and, at the other extreme, explicit and express transmission by precept and prescription, every society provides for structural exercises tending to transmit this or that form of practical mastery. Such are

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> the riddles and ritual contests which test the 'sense of ritual language' and also the game, often structured according to the logic of the wager, the challenge or the combat (duels, group battles, target-shooting, etc.), which require the boys to set to work in the mode of 'let's pretend', the schemes generating the strategies of honour. (Bourdieu, 1977, p.88)

4. The object of these exercises is, therefore, not to enlighten the individual's consciousness, but to train (and thereby 'inform') his or her 'body'. But this opposition between mind and body presents a second major problem for our understanding of Bourdieu's analysis. By 'body' Bourdieu does not mean a physiological entity as opposed to the mind as the seat of consciousness. For Bourdieu, the body is inescapably social because it is the bearer of the acquired physical and mental techniques that organise definite forms of social action and perception. So in Bourdieu's account, classifications are not based on invisible mental processes but on the acquisition of certain social techniques, or on what he elsewhere calls the 'socially informed body'.

   The socially informed body has the rituals and practices of social life inscribed on it, learned through the doing of those rituals. You have already come across this concept in the Marcel Mauss reading in Course HP05a, *Work in History* with its discussion of 'body techniques'. Mauss pointed out that we learn these techniques, how to swim, walk or march, in a particular habitus or social space and from our 'betters'. Body technique is a similar concept to the socially informed body.

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Read Pierre Bourdieu, 'The Berber house' (excerpts), reading 2.

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SAQ 3

The overriding theme of this reading is the identification of men with the outside and women with the inside of the house. Note some of the ways this distinction is:

1. embodied in the architectural organisation of the house,
2. produced in language, or
3. is part of the way the Berber act and move.

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Within the house itself, there is also a separation of dark and light, death and life, women and men. This separation is reproduced in the relationship between the house and the public world of mosque, cafe, fields. The Berber learn these distinctions by the development of a 'socially informed body', that is, by acquiring as habits a whole series of practices relating to the outside and the inside. There is a place to display the virgin bride, a place for marriage, a place for sexual relations close to the fertile grains. There is a ritual on the seventh day after birth to make one's son courageous and he also eats on the beam of the house that represents him to mark his passage to manhood. After marriage, he will sleep outside (unless it is wet), stride out certainly to his space at daybreak and eat facing towards the outside. Both language and habit invest the inhabited space with meanings that are reflected in proverbs.

Finally, two movements practised by women and men also have their symbolic content. The movements from threshold to fireplace for the women should bring plentitude, and from threshold to exterior practised by the men confirms the gifts of providence.

We will add to this analysis some of Bourdieu's other contributions. We should be very clear that by 'habitus' Bourdieu does not mean only observable, physical practices and techniques. He is quite happy to include unobservable mental practices and techniques in the habitus; for example, songs, word-games, puzzles, proverbs, techniques for inducing shame or pride and so on. The major point to grasp is that Bourdieu refuses to accept that these techniques of the mind all originate in a single natural mental process or consciousness, that is, in the individual as a human subject, to use our previous definition. There are too many of them, they vary too greatly from culture to culture, and between categories of social agent in a single culture for this to be the case, according to Bourdieu. Techniques of the mind, like techniques of the body, are acquired through definite forms of training practices as a social agent.

Bourdieu is freeing classification from the single form imposed on it by the scientific view which tends to be the view we have been trained in. He does so by tying classifications to the social practices of the habitus. These provide a whole array of classificatory capacities for social agents depending on the character of the cultural institutions in which they are acquired.

Because he thus refuses the distinction between social practices and cognitive processes, Bourdieu challenges our usual view of the relation of opposition between social institutions and individuals. We usually treat institutions as public organisations governed by formal or informal goals or functions. Individuals are usually set apart from these institutions by virtue of being governed by a private 'self', that is, a principle that unifies all the

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individual's thoughts and actions in a single cognitive process: consciousness.

Bourdieu modifies this view in two ways.

1. According to Bourdieu, institutions are not governed by general social goals but by the particular social practices and techniques of the habitus out of which they are composed. Hence, all sorts of things count as institutions for Bourdieu. Not only clearly visible institutions like the Berber household and the institution of marriage, but also much smaller and less obviously public practices - games, jokes, proverbs and songs. You discussed both significant social practices - like rites of passage - and less grand rituals like the salute, in your reading of Pocock in Course HP01b, *Traditions*. These are too numerous and dispersed through the social fabric to be reduced to a single general cause or function.

2. The individual is not conceived as defined in opposition to these institutions. The relation is much more intimate than this. Bourdieu argues that the individual's capacities are acquired from the institutions he or she inhabits. There is no such thing as the individual for Bourdieu, only definite capacities that individuals exercise in specific institutional contexts.

In Hempel's account, the role of social institutions in relation to classificatory knowledge was limited and largely negative. The institutional training of psychiatrists in certain observational norms and procedures is to be stripped away, as far as possible, to reveal the natural power of direct observation to which a true psychiatric observation would ideally conform. Only then will observers agree, by virtue of seeing the same thing; only this agreement permits a uniform application of classificatory categories. Hence, for Hempel, the social uniformity of classificatory procedures depended on the intersubjective agreement of individual observers (and ultimately on the natural uniformity of the properties seen by the observers). Bourdieu reverses this relation of dependence. If social institutions have the positive role of providing individuals with the capacities for making classifications, then the relative uniformity of classifications results from the relative uniformity of institutional roles, not from a universal process of recognition. Hence, for Bourdieu, the intersubjective agreement of individual observers depends upon the social uniformity of the classificatory procedures that they employ. If this is the case, classifications will not arise from universal 'ideas' and 'perceptions' but from particular and variable social institutions and practices.

The Berber woman shares her view of reality with that of other Berber women because she inhabits the same space, because she performs the same role, because she lives in a

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world seen from the same perspective. Her 'socially informed body' is inscribed with the practices of her world. She learns the meanings and actions that make her a Berber woman and practices them in her movements through her social space.

For us, it is natural to think of education as something centred in the use of language, and the printed word in particular; that is, as a process in which the pupil's consciousness is addressed through the meanings extracted from words. Bourdieu's point is that in societies lacking specialised institutions like the school, where training is centred in speech and writing, education goes on nonetheless. This suggests that linguistic meanings need not be the essential part of the formation of human capacities. Other social activities like games, ritual combats, dances, designing houses, etc. may function as means of building up human capacities for classification. Further, in Bourdieu's account, the possession and exercise of classificatory capacities is not governed by an individual's general relation of recognition to the natural world, but by the places individuals occupy in the institutions of the social world. It is individuals seen in this light that Bourdieu describes under the curious heading of the socially informed body. Although similar to the notion of socialisation and learning a social role, this concept means something more. It refers not to the notion of consciously acting social agents but social members in whose bodies the roles of society are written and imposed. The concept of the socially informed body is used to:

> ..reconstruct the principle generating and unifying all practices, the system of inseparably cognitive and evaluative structures which organizes the vision of the world in accordance with the objective structures of a determinate state of the social world: this principle is nothing other than the socially informed body, with its tastes and distastes, its compulsions and repulsions, with, in a word, all its senses, that is to say, not only the traditional five senses - which never escape the structuring action of social determinisms - but also the sense of the necessity and the sense of duty, the sense of direction and the sense of reality, the sense of balance and the sense of beauty, common sense and the sense of the sacred, tactical sense and the sense of responsibility, business sense and the sense of propriety, the sense of humour and the sense of absurdity, moral sense and the sense of practicality, and so on. (Bourdieu, 1977, p.124)

It should be clear that by 'body' Bourdieu does not mean the structure of organs and processes described by medicine and biology, nor the mechanical capacity to respond to stimuli described by psychology. Instead, he means the set of capacities to perform certain actions and master definite

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techniques which, while having biological conditions, are socially produced and maintained (like the men sallying forth in the morning). Hence the bodily 'senses' described by Bourdieu are less the 'natural' senses of sight, hearing, touch, etc., than the capacities built up by the social institutions that inform or invest themselves in the body. Where classifications are concerned, Bourdieu argues that they do not derive from a single basic natural power to observe and conceptualise the common properties that demarcate one class of objects from another; they are developed and maintained in a whole range of social practices and techniques that determine particular forms of 'observation' and 'conceptualisation'. This analysis has two important effects on our inquiry into classifications:

1. It means that classification is culturally specific, arises out of particular social circumstances.

2. It means that our focus will not be on classificatory terms or concepts as such nor on the question of whether they reliably represent natural properties and class boundaries. Rather, we wish to address the array of social institutions and practices in which these terms and concepts take effect (the example of psychiatric classification of the 'insane' provides a rich field).

This second point can be clarified by addressing the effects of the organisation of inhabited space in the Berber house. Not only does the design of the house form part of a technology for recognising difference between men and women (by placing women's work with the animals, by representing the women as the pillar and the men as the beam; it also plays an important part in forming the characteristics that differentiate men and women (for example, by making it characteristic for women to walk head bowed into the house and for men to walk head erect out of the house towards the public places where women are forbidden). Hence, it is beside the point to ask whether the classificatory distinction between male and female (so central to the entire system of Berber classifications) is a reliable representation of the observable characteristics of Berber men and women.

Now we can see why Bourdieu's description of the socially informed body - that is, of the array of social techniques and practices that invest individuals with definite capacities and conducts - frees classification from a single scientific account based on the 'proper' conceptualisation of the categories. Classifications, like those that distinguish male from female in Berber society, are inseparable from a whole variety of operations. Many of these are practical activities such as performing rituals, enforcing social norms, teaching certain techniques and linguistic forms.

The effect of the principle of the socially informed body is thus to disperse the functions of classifications

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across different institutional practices. It replaces the scientific assumption that individuals classify as they do because they have a single true relation to reality, with a view of classifications as a set of diverse and varying historical and cultural practices.

Clearly the move from the scientific to the sociological (anthropological) description of classifications provides us with a greater theoretical flexibility in that it frees classification from a single foundation in an unchanging human nature.

In order to clarify the options now at our disposal, we will examine a particular classificatory system, the example of psychiatric classification in sections 3 to 6 of the study guide. However, before we pass on to this main example we can undertake a preliminary exploration of these options by considering the kinds of history that they make possible.

2.4 Introducing time

Our two frameworks produce a different way of constructing history, including the history of classifications:

1. With the scientific framework, the history of classification is essentially the process of stripping away the social factors that distort the universal capacity to recognise the natural characteristics of class members. In this view, history is progressing towards a single ultimate goal: the point at which a subject sees an object, with both vision and knowledge purified of social norms, subjective values or historical conventions. History is thus a record of the passage from error to truth - a story of the stupidity of our ancestors, except in so far as they anticipate what we call scientific classificatory knowledge. The history of a knowledge is essentially a history of errors. For obvious reasons such histories are, as we indicated on p.9, called 'progressivist'; you will meet them again in Course HP08b, *Disciplines*, under the heading of 'Whig' history. Our example of this sort of history for mental illness is provided by Zilboorg and Henry - to be taken up below in section 3.2.

2. If we approach classifications from the direction of sociology or anthropology, then their history is that of the emergence of the multiple social institutions and practices in which classificatory capacities are formed and maintained. Under these circumstances there is no single linear history moving forwards in a particular direction, because there is no goal provided by the subject's final true recognition of the nature of objects. In other words, there will be no general history of knowledge in which people have (so it is said) always been struggling towards the sort of things

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that we call scientific representations. On the contrary, this second type of history will consist only of particular descriptions of the institutions and practices by means of which actions have been performed, techniques mastered, social norms and values enforced, techniques of the body and mind inculcated and, thereby, a diverse array of classificatory capacities formed and maintained.

We will see below that this second, sociological type of history splits into two models. The first, the ideological, sees these social processes as masking reality, as obscuring the true classificatory boundaries that order classes of things in the world. Erving Goffman, Thomas Szasz and Andrew Scull are dealt with below as proponents of this model as a means of understanding the role of psychiatric classifications and institutions.

There is another view, however, that seeks to avoid the imposition of a single criterion for correct and incorrect classifications, but rather focusses on how classifications are constructed in practice. To foreshadow this approach, we can usefully recall the very start of the course. In the case of the Kalam classification of birds in which women show themselves (i.e., that represent women in dream experience), it is inadequate to treat this as a pre-scientific error or as a primitive anticipation of our own ornithological classifications. The third approach, via the principle of the socially informed body, permits us to treat the Kalam classification not as the result of an observation distorted by superstitions or erroneous social beliefs, but as an observation informed by a set of practical techniques unfamiliar to us: techniques for staging and interpreting dreams by means of ritual descriptions of bird life. In other words, scientific and ideological concerns would force us into unhelpful comparisons - for example, ritual practices for constructing sexual identity with modern experimental biology. It would be much more revealing to compare the Kalam classification with certain practices and techniques involved in psychoanalysis. Psychoanalysis also involves the staging and interpretation of dreams by means of ritual descriptions, including the sex life of the family. Hence it involves the formation of definite classificatory capacities and functions that are irreducible to the norms of modern experimental sciences. Of course, this does not mean, as Hempel infers, that psychoanalysis is still founded on an error that the progress of reason will eliminate, no more than the Kalam classification of birds is.

If we are to begin to understand something of the variety of things that count and have counted as classifications, then it is not enough to apply these lessons only to so-called 'primitive' cultures. That would be too easy. One must also learn to apply the same lessons to the history of our own classificatory systems. This is harder and more contentious. However, it is precisely what

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is required if we are to understand the history of psychiatric classification. Let us supplement the example of the Kalam classification by briefly looking at a classificatory system from our own Western past: the system of natural history as it was in the sixteenth and seventeenth centuries, prior to the emergence of identifiably modern botanical and zoological classifications.

Look back to Henry Peacham's rhinoceros, reprinted on the title page of this section; this image gives a rough idea of the difference between early natural history and the botanical and zoological classifications with which we are nowadays much more familiar.

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Re-examine Henry Peacham's rhinoceros on the title page of this section.

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Perhaps the most striking thing about the emblem and text is that they do not obey the distinction, that is natural for us now, between interpreting symbols and describing characteristics. The rhinoceros, for Peacham, is both a symbol to be interpreted for a moral lesson, and a creature in nature or history whose characteristics have been recorded in stories. At that time, the capacities for observing and categorising natural species were crucially determined by the presence of techniques for transcribing and interpreting ancient texts. Hence the recognition of the important characteristics of animals was determined by a whole range of techniques now unfamiliar to us, including staging ritual combats and learning exemplary stories of animals as moral lessons, in addition to describing the way they looked. Even the process of describing how the animal looked was governed by historical techniques, as we can see from Peacham's woodcut where the rhinoceros seems to be wearing his armour like a medieval knight rather than growing it!

We can further develop these points by looking at an extract from *Pliny's Natural History*. This is an even earlier document, a Roman work dating from 77 A.D., but it served as a popular natural history during the sixteenth and seventeenth centuries. This is the reading for Tutorial One. If you do not attend the tutorial, you may still like to do the exercise.

From Course HP07b, *Penal Colony 2*, you discovered that commentators, apparently discussing the same history or same set of facts, could actually reach very different interpretations and conclusions. As you found out, some debates concern the interpretation of documents or evidence while others concern the theories or assumptions that historians bring to the analysis of those documents. In the remainder of this course, we are going to analyse three

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histories of the emergence of mental illness as a specific category of illness. This will be called the history of psychiatric classification. You will discover that the particular history told - the 'facts' it deals with and how they are interpreted - influences the way in which mental illness is classified. We will study three examples of the history of psychiatric classification as discussed previously: a scientific progressivist history, a sociological-ideological history and a sociological history which attempts to avoid these assumptions of ideological imposition. These three variants are briefly summarised as follows:

1. Zilboorg and Henry in their standard *History of Medical Psychology* adopt the perspective of the 'progressivist' history of science. They treat the emergence of the classification of a specifically mental (as opposed to bodily) illness at the end of the eighteenth century as the final chapter in the long struggle of science to eliminate superstitions and social beliefs from medical observation and thereby reveal a natural division between the mentally sick and the mentally healthy.

2. Andrew Scull, on the contrary, in his sociological history *Museums of Madness* treats this event as the result of the imposition of new norms of social conduct. The result is that the psychiatric classification of the mentally ill emerges as an ideological misrepresentation of a group whose only 'sickness' is to deviate from the new social norms.

3. Michel Foucault in his *Madness and Civilization* takes up the third position, permitting us to give new content to Bourdieu's concept of the socially informed body. According to Foucault, the history of psychiatric classification cannot be the story of the scientific discovery of mental illness, or of its ideological imposition as a fictitious category masking the repression of the socially deviant. For him, it must take the form of a description of the changes in cultural institutions and practices that make 'mental illness' historically possible. This history is discussed in sections 4 and 5 below.

By comparing Zilboorg and Henry with Scull, in section 3 of the study guide, we will be able to chart the limitations of the histories of psychiatric classification that flow from the theory of science and the theory of ideology, respectively. This will enable us to explore Foucault's description of the way in which the reorganisation of the inhabited space of confinement and the emergence of new medical techniques make the classification of mental illness a historical possibility.

TUTORIAL ONE

1. Discussion of the preliminary exercise on the Kalam classification of birds.

2. Read the excerpt from *Pliny's Natural History*, reading 3.

   Note one or more examples of:

   a. the observation of animal behaviour

   b. hearsay

   c. the compilation of stories from other texts or authorities

   d. the interpretation of animals as symbols containing moral lessons

   e. the reading of animal behaviours as signs or 'tokens' inscribed in them by Nature so that people can understand them.

Which of these procedures would you be most likely to find in modern classifications of animals?

In what ways do the other procedures differ from modern approaches?

How would Hempel treat this reading?

You may like to analyse a couple of paragraphs from the Pliny excerpt and imagine the objections Hempel would make.

3. The tutorial will also provide an opportunity to discuss the SAQs up to this point.

3 TWO TYPES OF REASONING ABOUT MADNESS

Though this patient was much less disposed to converse upon the subject, his hypochondriacal ideas remained, as the following description of himself, taken nearly verbatim from his own mouth, will prove: 'I have no soul; I have neither heart, liver, nor lungs; nor any thing at all in my body, nor a drop of blood in my veins. My bones are all burnt to a cinder: I have no brain; and my head is sometimes as hard as iron, and sometimes as soft as a pudding.' A fellow patient, also an hypochondriac, amused himself in versifying this affectingly ludicrous description in the following lines:

A miracle, my friends, come view,
A man, admit his own words true,
  Who lives without a soul;
Nor liver, lungs, nor heart has he,
Yet, sometimes, can as cheerful be
  As if he had the whole.

His head (take his own words along)
Now hard as iron, yet ere long
  Is soft as any jelly;
All burnt his sinews, and his lungs;
Of his complaints, not fifty tongues
  Could find enough to tell ye.

Yet he who paints his likeness here,
Has just as much himself to fear,
  He's wrong from top to toe;
Ah friends! pray help us, if you can,
And make us each again a man,
  That we from hence may go.

From Samuel Tuke's
Description of the Retreat
1813.

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3.1 A new class of madmen

Before proceeding to our three histories of mental illness, the changes that occurred in the institutionalisation and definition of the insane will be discussed briefly. This provides a framework for the histories which follow. Two major changes occurred. Firstly, the insane came to be housed and defined separately from other groups of incarcerated people. Secondly, the definition of insanity came to be based on moral and then medical criteria, an illness not of the body but solely of the mind.

In England and throughout Europe prior to the end of the eighteenth century the insane were not housed or confined separately from a much larger social group. Instead, along with beggars, vagabonds, criminals, debauchees and disreputable individuals, they were collected in a variety of institutions under a variety of provisions aimed at preventing social mischief, relieving poverty, incarcerating criminals and banishing the scandalous from public view; some institutions fulfilled a number of these functions. The specialised mental hospital in its modern form did not exist.

Neither, at this time was there a distinct discipline - psychiatry - that took mental illness as its distinctive and particular concern or object. Instead, mental disorders were classed and treated along with other disorders by the general medicine of the day. Here they occupied a marginal and uncertain position. Diseases like hypochondria could shift category from bodily to mental ailment precisely because body (soma) and mind (psyche) were not at that time distinct objects of different medical disciplines. For the same reason similar medical techniques (e.g. bleeding, purging) were directed at both the body and the mind, and particularly at what were taken to be their meeting points - in the temperaments and passions. But if eighteenth century madness was not 'mental' in the way we understand this term neither was it an 'illness' in the modern sense. Mental disorder was still too closely identified with the sorts of errors in judgement that we now classify as philosophical for it to come under our heading of 'illness'. Thus purgings and bodily shocks (for example, being ducked in a cold bath), were often administered to dislodge incorrect and fixed ideas from the mind.

By the end of the eighteenth century, however, the cultural system that dealt with madness was in a dual process of change:

1. The old order of general confinement was replaced by a new system of specialised institutions. At the beginning of the nineteenth century, a network of lunatic asylums was established, in which the insane were both housed separately and defined as different.

2. A new medical definition of insanity became possible. This was one in which madness simultaneously became a

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purely mental (or moral) phenomenon and an illness, perhaps of the brain or perhaps of the moral sensibility alone. At any rate, it was an illness of a type that was irreducible to the normal range of organic ailments. It had a range of psychological or moral causes that could not be reduced to a general disorder of the reasoning faculty. These were the hallmarks of the emerging disc pline of medical psychology (psychiatry) or moral psych ology as it was also called.

A new classificatory system emerged, marked on the one hand by the appearance of the asylum as the place where the members of a special class were confined and, on the other, by the emergence of moral psychology, or psychiatry as it was soon known. It is the appearance of this new system that we will use to further our investigation of classifications. In particular it will enable us to explore the three alternative histories of psychiatric classification. Before doing this we shall look at Michael Donnelly's discussion of the emergence of the asylum (reading 4) and of the new definition of insanity (reading 5).

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Read Michael Donnelly, 'Perceptions of lunacy in early nineteenth-century Britain' (excerpts), reading 4, and answer the following questions.

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SAQ 4

Donnelly identifies the 'pauper insane' and the 'insane of property' as two categories thrown together with other workhouse inmates. How were the insane defined (i.e., what characteristics did these two categories share)? Who certified the insane?

The emergence of separate confinement clearly involves a shift, at once physical and symbolic, in the organisation of the cultural space in which the 'object' insanity is set apart. Insanity ceased to occupy an undifferentiated space defined by a widely shared social incapacity or general irrationality. It entered the specialised institutional space of the asylum and the conditions of its entry were the definitions and knowledge of mental states and capacities provided by moral psychology. The insane became separated from other inmates (paupers, etc.) through a new sensitivity to their failure to perform their normal social duties.

Second, let us take a preliminary look at the change in the medical knowledge of insanity that occurred at the same

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time as the establishment of the asylum. This was a change from seeing madness as a result of temperament (body as much as mind) to a result of mental state. This change is described in reading 5 and on pp.175-77 of Hirst and Woolley's *Social Relations and Human Attributes*. Reading 5 continues Donnelly's history of changes in the social perception of lunacy, while the excerpt from Hirst and Woolley is taken from their exposition of Foucault's *Madness and Civilization*. We will be returning to Hirst and Woolley and Foucault in sections 4 and 5, so don't worry too much about the finer points of this account at this stage. For the moment, simply use the excerpt to gather a broad understanding of the changes in the medical knowledge and treatment of insanity that occurred at the end of the 'classical' age.

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Read Michael Donnelly, 'Perceptions of lunacy in early nineteenth-century Britain' (excerpts), reading 5; and Hirst and Woolley, *Social Relations and Human Attributes*, pp. 175-77.

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SAQ 5

1. According to Donnelly (R5:2), what kind of relation existed between the new asylums and the emerging discipline of medical or moral psychology?

2. In a short paragraph, summarise the main points of difference between eighteenth-century madness and the new classification of mental illness isolated by Hirst and Woolley.

We have now described two closely associated groups of changes by which the classificatory boundary that separates the mad from the sane was reconstructed at the beginning of the nineteenth century. The changes occurred, more or less together, in the cultural institutions that defined and confined the insane as a particular and definable class of persons, and in the medical knowledge of insanity that now became a distinct discipline with its own object: a purely mental or psychological illness. Note that we have said nothing to prejudge the relation between these two orders of change, i.e., to suggest that changes in incarceration caused changes in medical knowledge, or vice versa. Our task has simply been to familiarise ourselves with the character and extent of the change in classification. This provides us with a 'field' in which we can investigate the contrasting scientific and sociological views of such shifts in classification. In fact, both forms of explanation have

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been applied to the emergence of 'mental illness'. We begin now our three historical 'interpretations' of these events.

3.2 The progress of reason

The 'progressivist' history of science is, in this case, the history of the emergence of the science of psychiatry out of the mists and myths of superstition and prejudices. In this history, great men play a crucial role in penetrating these superstitions and prejudices; they act as original thinkers in banishing the myths that beset ordinary people. Mental illness was always there but only with the progress of reason was it gradually discovered by these great thinkers. As a result, this kind of history is a series of character sketches of our insightful heroes coupled with a catalogue of their great works. We are not unfamiliar with this kind of history in our daily lives. Biographies are written as a celebration of great men and women. Documentaries on Lister or Pasteur focus on the discoveries of these clever men. We tell stories about the Hawke government, the Whitlam years. These stories are our social institutions, just as the Berber household helps build up the Berber people's social institutions.

On the one hand, then, we have a notion of individuals making history. However, coupled with this is a notion of those individuals making history as a series of breakthroughs. They are human subjects who think the breakthroughs rather than social agents who are constructed by their habitus. Finally, because these great men are stripping away the cultural prejudices that cover true classification, their breakthroughs are really only rediscoveries of something that was always there to be known, the natural boundary between the insane and the sane.

Reading 6, from Zilboorg and Henry's standard history of medical psychology, provides us with a good example of the history of psychiatry treated as a science. It has resonances with Hempel's scientific classification of mental illness. First there is the centrality of thinking individuals (as opposed to collective cultural norms and socially informed bodies). Secondly, their powers of observation result from stripping away cultural values and stereotypes which contaminate their gaze. But finally, every discovery is only a rediscovery of the 'natural' classification of mental illness.

Our interest in Zilboorg and Henry will be to exemplify and clarify the three features we have identified as characteristic of scientific histories:

- the story of breakthroughs
- the centrality of great individuals
- the repetition of discovery

It is important to be clear about this because we usually read histories to learn about dates, events and the reasons behind them; in short we read them for the 'facts'. In Zilboorg and Henry's history the facts take a back seat.

You have already been introduced to the facts of the birth of mental illness from reading Donnelly. Here you will be asked to interpret Zilboorg and Henry's construction of those facts, i.e., to interpret their interpretation. This, as you learned in Course HP07b, *Penal Colony 2*, is called historiography. It will require you to suggest why Zilboorg and Henry discuss the personalities of their great thinkers or what the role of certain stories in their account is.

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Read Gregory Zilboorg and George Henry, *A History of Medical Psychology*, (excerpts) reading 6.

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SAQ 6

Make a list of the factors which are said to obstruct the discovery of mental illness on R6:1 and 2. What do they have in common? How are these obstructions usually overcome?

For Zilboorg and Henry, social institutions (religion, political parties, philosophy, the law) and social techniques (language, theoretical procedures) are merely obstructions to the exercise of an individual's power of observation that owes nothing to them. This is why the authors treat social institutions as similar to superstitions, prejudices and irrational cruelties. (One can imagine that if Zilboorg and Henry were to write a history of ornithology then they would treat the Kalam bird classification as a primitive misrepresentation, insufficiently detached from social ceremony.) Breakthroughs result from individuals who break free of their social situation and thereby see beyond the social blinkers worn by the mass of their fellows. Indeed, this is what their 'greatness' consists in.

Bourdieu, of course, would argue that the idea of breaking free of culture does not make sense; because in his account the individual is the sum of the social capacities and attributes stored up in cultural institutions - like the Berber household. Leaving this larger difference to one side for the moment, let us look at how these biographies function in this particular history.

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The reading has been edited to deal primarily with one of the first of the great men, Georg Ernst Stahl, and several of those who lived during the great transformation of mental illness - the Tukes, Daquin, Pinel.

SAQ 7

Note down the major personal characteristics that Zilboorg and Henry attribute to Stahl, Daquin and Pinel. Identify any points of similarity between your lists.

All of Zilboorg and Henry's great men of science were defined by their degree of removal from the surrounding social context. Perhaps this is simply a coincidence. Perhaps, on the other hand, we are dealing with the same story told over and over again with different names and dates - the story of the independence of scientific discovery from the historical and social context in which it occurs. Leaving aside the truth of this story in any particular case (surely at least one of these scientists could be rich and corrupt!), our interest is in the fact that it is repeated; just as Bourdieu is interested in the repetition of certain sayings and practices on ceremonial occasions.

A ceremonial story then, with a function. Its function is to disengage psychiatric knowledge from its social institutions. The separation of the mentally insane is, in Zilboorg and Henry's account, nothing more than the architectural realisation of the scientist's perception that the insane are a different species. They saw the light, saw the true classification of madness and so they separated the mad. The throwing together of criminals, paupers, vagabonds and libertines with the insane takes on the character of an error; an observational and ethical failure on the part of the observer to recognise a 'problem which could not have escaped his observation'. Scientific knowledge is dramatised in that moment where Pinel confronts the enchained inmates of Bicetre and sees them for what they are.

This leads us to the second point about our great men of psychiatry, a point that forges links with Hempel's account of scientific classification. For Hempel, this depends on observation, description and finally explanation in terms of underlying causes. Thus we discover that Daquin sees the mental hospital as a place of research, a place where one can learn psychiatry and make new investigations. Pinel introduced the taking of psychiatric case histories and 'made careful notes' of what his patients did and said (remember the untidy hair and chewed fingernails that Hempel's scientist observes). Finally, it was the hospital that allowed intersubjective comparison of the results of observation, 'comparing and verifying the tests on a sufficient number of patients or variety of mental illness'.

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To Zilboorg and Henry, then, madness is always there and it is always the same. Successive breakthroughs by great men rediscover it. As we shall see, both Andrew Scull and Michel Foucault contradict this account by insisting that 'madness' is not the same phenomenon in different historical periods and that the forms of its observation and classification differ too. To Scull, madness is a result of ideological imposition of a social category by a powerful group, the doctors, working in alliance with the ruling class. It has economic causes - the need for a working class for the new factories; and political processes - it is the exercise of power. It is to this sociological-ideological history we now turn.

3.3 The imposition of ideology

You will remember that in section 2 we explored the difference between scientific accounts in which classifications are pictured as grids over nature and anthropological and sociological accounts in which classifications are pictured as products of culture.

We have just reviewed the scientific account of the emergence of mental illness. We have already anticipated the strikingly different character of the sociological history of psychiatry. In this second kind of history, the emergence of the category of a specifically mental illness is treated in terms of the formation of a 'myth' or ideology. You have already been introduced to the concept of ideology in Course HP03a, *Community and Identity*, and Course HP04a, *Cultural Formations*. This is an extension of the sociological approach to classification discussed in section 2.3 above. Our example there showed that classifications are social constructions. They arise out of, and shape, the social practices of a people. This means that they are neither reliable nor unreliable, objective nor subjective in the sense that Hempel's account distinguishes these conditions. However, embedded in these accounts is often the notion that socially constructed classifications are false, are an ideological gloss or cover over real relations in society. This ideological gloss is seen to be at the services of powerful groups in society, e.g. the psychiatrists in the case of mental illness.

Many of us read Goffman's *Asylums* with the suspicion of the scientist. 'But some people really are mad' we feel like responding. Goffman, in a sense, neither confirms nor denies this possibility. However, the thrust of his analysis is that madness is socially constructed, the result, in effect, of the process of psychiatric classification itself. A whole series of social actions, e.g. the 'stripping of the self', recreate (presumably normal) people as mentally ill. He describes the ways in which the staff control, reinforce and define the mentally ill.

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Goffman spells out the ideological role of medical categories in psychiatric institutions. According to Goffman they provide an 'interpretive frame' or cover for the real functions of such institutions: the social control of the inmates. For example, describing patient behaviour in medical terms like 'excited' or 'disturbed' is a way of translating the patient's quite legitimate attempts to assert his or her self-identity into signs of illness. 'Curing' patients, so Goffman argues, amounts to getting them to internalise socially acceptable moral values and norms of conduct under the guise of providing them with medical treatment.

The implicit assumption is that mental illness is purely a social construct, but also a social construct used by powerful people to control other people. In this section, we will focus on proponents of the sociological approach who emphasise its ideological effect, the way in which it 'misrepresents' reality in the service of the powerful. Foucault, who represents our third approach, avoids this distinction between truth and ideology and also avoids the notion of a 'socially constructed reality' produced intentionally by social actors.

We can simplify our task by comparing Zilboorg and Henry's history of psychiatry with a sociological history that treats 'social construction' almost wholly under the heading of ideology. This at once provides us with a stark contrast between scientific and sociological histories while permitting the contrast itself to set the scene for our inquiries in sections 4 and 5, where we will return to the notion of the 'social construction of reality'.

In order to come to terms with the ideological approach we need to be clear about exactly how mental illness is supposed to function as an ideological category or myth. Reading 7 by Thomas Szasz, helps us to do this and thereby serves as a preparation for the longer historical reading that follows. Szasz argues that there is no such thing as mental illness, or diseases of the mind. The things that we label mental illness are either diseases of the brain caused by neurological defects, syphilis, alcoholism, etc. and hence belong in organic medicine not psychiatry; or they are not illnesses at all but simply forms of conduct and speech that happen to have been judged unpopular or troublesome - what Szasz calls 'problems in living'.

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Read Thomas Szasz, 'The myth of mental illness' (excerpt), reading 7, and complete the SAQ overleaf.

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SAQ 8

Zilboorg and Henry (the story of Couthon's exchange with Pinel, R6:6) Donnelly (R4:5) and Szasz all provide us with an explanation of the relationship between the political arena of the state - the revolutionary commune, the political references, the law courts, and the classification of mental illness. What is the relationship in each case?

It is no accident that Zilboorg and Henry construct scientific wisdom as something which has to fight through the less significant but intensive political events of the day. Nonetheless, in the scientific account, politics and science are separate entities. To Donnelly, the two are intimately interwoven although here the political events make possible the medical identification of the insane. Szasz, finally, sees medical or 'scientific' definitions in the service of whoever chooses to buy the services of psychiatrists, whether it be courts, military or the patient. As we will see below, the relationship between state and medicine is more clearly drawn by Scull. This notion of psychiatrists as mere 'sellers of definitions' is possible because they deal only in social constructions of mental illness, only in ideology.

If the psychiatric classification of mental illness is inseparable from the imposition of social norms and values then, unlike the diagnosis of organic illness, there can be no real division in nature between the mentally ill and the mentally healthy to which the psychiatric classification can correspond. Szasz explicitly locates the psychiatrist as the central defining agent of medical illness and indicates the way in which medical definitions have (erroneously) intruded into ethical and legal areas. Szasz suggests that psychiatry is in the service of law and order - it cannot testify that the legislators are insane.

Szasz's and Goffman's account of the ideological function of the category of mental illness is in striking contrast with Zilboorg and Henry's history of its scientific discovery.

Goffman and Szasz say mental illness is an ideological classification while Zilboorg and Henry say it is scientific. To Zilboorg and Henry, ideological classifications are made by those who saw it as the result of evil spirits or Christian souls. But if Szasz and Goffman see modern classifications as ideological, they must have a pole of truth to measure the mistake against. After all, Henry and Zilboorg know that medieval classifications are ideological because modern ones are scientific. How do Szasz and Goffman know that modern definitions are

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ideological? What would a true classification look like? They must ask this last question, at least implicitly, to know that the present classification system is a misrepresentation, an ideological mask, of something that is truth.

Thus, these two quite different histories have the same poles - that of science/truth/representation and the opposite one of ideology/false consciousness/misrepresentation. The history of mental illness as an ideological representation is the history of how purely social powers and interests have been translated into a misleading medical frame of reference. This is exactly the history of separate confinement and the emergence of psychiatric classification offered by Andrew Scull in reading 8. This excerpt is divided into three sections. The first deals with the 'structural' formation of the social norms and values that, according to Scull, permitted the segregation of the mentally ill in asylums at the beginning of the nineteenth century. The second and third treat the emergence of modern psychiatry and mental illness in terms of the ideological translation of these social norms and values into what looks like a medical fact.

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Read Andrew Scull, *Museums of Madness* (excerpts), reading 8. Because this is a fairly long excerpt you might read it through once quickly now in order to gather the overall structure of Scull's analysis, then we will deal with each section separately. So re-read section 1 more carefully.

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In the first few pages of section 1, Scull sets up his task: to account for the separate confinement of the mentally ill at the beginning of the nineteenth century and the parallel emergence of an autonomous knowledge of a specifically mental or psychological illness. This is essentially the same task that Zilboorg and Henry undertake.

SAQ 9

In a short paragraph, describe the way in which Scull (R8:1 and 2) separates his approach from those based on the assumption of progress in humane concern and scientific understanding.

The following sentence from Scull indicates the fundamental affinity between his approach to the category of mental illness and that of Szasz and Goffman:

Quite regardless of one's opinions on the extent of

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> scientifically-based psychiatric knowledge of mental illness today, there would, I think, be a widespread consensus on the dearth of almost any real knowledge base in early nineteenth-century medicine which would have given the medical profession a rationally defensible claim to special expertise vis-à-vis the insane. (R8:2)

In other words, in an explicit rejection of the type of history represented by Zilboorg and Henry, Scull argues that the separate classification and confinement of the insane as mentally ill was not the result of a development in scientific knowledge, but of quite other factors.

The bulk of Scull's analysis in section 1 concerns the way in which changes in the English economy produced new norms of conduct in relation to industrial work (some of these changes were considered in Course HP05a, *Work in History*). The rising bourgeoisie were reliant on a 'free' labour force for their factories. It was crucial to them that peasants forced off the land could not be supported in poor houses to avoid entering the factories. Poor laws were reformed to force able-bodied persons to work for a living or face an even less desirable alternative in the harsh rigours of the work-houses. The redefinition of the insane as a separate category was a separation of the especially troublesome, who would not submit to the requirements of work discipline. This meant that the remainder of the incarcerated could more effectively be forced to work.

SAQ 10

What, according to Scull, were the main economic factors that led the 'elite' to adopt a strategy of institutionalisation?

It is only relative to this general ruling class strategy of institutionalisation that the insane are segregated as a specific sub-class of the 'problem population' formed by the new patterns of work discipline. In Scull's account, the demand for the separate confinement of the insane springs from the problems posed in disciplinary institutions such as work-houses, factories and schools by all those who could not or would not abide by the rules and regulations. For Scull, the insane are literally all those who voluntarily or involuntarily resisted the new norms and values of wage labour. More precisely, they were the population formed by all those who resisted these norms in the very institutions designed to produce a disciplined labour force.

You can see the way in which Scull marries the theses of Szasz and Goffman to a Marxian theory of ideology. Like

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Szasz and Goffman, Scull argues that the medical categories of psychiatry (moral psychology) could not possibly represent their supposed object - mental illness - because they involve the application of social norms and values. However, for Scull these norms and values do not originate in personal conflict (as in Szasz) nor in the functional requirements of 'total institutions' (as in Goffman). Rather, they were determined by the maturation of the 'capitalist market economy' which established new norms of social performance as required by the discipline of industrial work. You can judge the relative importance of this difference for yourself. What is important is that Scull, like Szasz and Goffman (and, paradoxically, Zilboorg and Henry), continues to use the notion of the presence of social norms in the process of classification to identify the ideological character of psychiatry. For Scull, too, mental illness is a categorisation used by powerful groups - the bourgeoisie, the doctors - for their own ends. Scull treats the emergence of a new medical knowledge of a specifically moral or psychological illness as the ideological translation of socio-economic needs and problems into the medical domain.

Scull describes the process of translation in the second and third sections of the excerpt. Section II describes the emergence of the classification and treatment of a purely moral or psychological 'illness' at the end of the eighteenth century. (You will remember that for most of that century insanity had been treated as a marginal category in general medicine, as a general disorder and not the affliction of a distinct psychological domain.) Section III treats the formation of the category of mental illness in terms of the rise of psychiatry as a distinct profession in the division of labour.

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Re-read sections II and III of Scull, reading 8.

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We have seen that in Zilboorg and Henry's account of the emergence of the new classificatory system the separate confinement of the insane is described as the result of the scientific discovery that a certain section of the confined population is mentally ill (rather than criminal, lazy, debauched, etc.). In Scull's history this relation is reversed. First, the insane are segregated in special asylums because of the trouble they cause in general confinement. (This segregation results from the imposition of new norms under which the insane appear as the least disciplined of the 'problem population'.) Only then does psychiatric classification and treatment of the asylum population as mentally ill emerge as the convenient ideological rationalisation for this existing disciplinary confinement. Such is the account that Scull introduces at the beginning of section II.

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SAQ 11

Why does Scull view insanity as a non-medical category and how does this view affect his account of the character of the 'medical capture' of insanity?

A key factor in the 'medical capture' of insanity is a shift in the cultural meaning of madness. In the eighteenth century the mad had been classified as brutes and their treatment had been brutalising because they were perceived as beings without reason but not as necessarily sick. By the beginning of the nineteenth century the madman is not totally deprived of reason but is the victim of often local and temporary disorders of his moral (i.e., psychological) faculties. We have already traced this change in perception, that takes madness into the domain of mental illness, in Zilboorg and Henry's history of psychiatry. There the birth of the 'moral treatment', or a specifically psychological medicine, is the outcome of a long struggle to wrest the scientific observation of psychological symptoms from the long night of superstition and cultural 'preconceptions'.

SAQ 12

For Scull, the emergence of the moral treatment, with its emphasis on the production of self-restraint via psychological management, has quite other causes. What in general terms is the character of the causes analysed by Scull?

Scull treats moral psychology as an essentially non-medical management of a population defined only by their social deviance. But he is quite aware that this management is carried out in medical terms on individuals who are identified by means of psychiatric classification of their mental states and capacities. According to Scull, the insane were set apart by the social necessity to enforce the new norms and values of work discipline. But it is not clear in his account why they were picked out of the 'problem population' specifically by reference to their moral or psychological health. Scull is not too concerned with this problem because, in his analysis, the populations of schools, prisons, work-houses and insane asylums are all subjected to a common determination: they are being imbued with the norms of self-restraint and the regularity of conduct necessary for the new forms of industrial labour. Yet if Scull is not concerned to mark differences between these populations, the institutions themselves were keen to

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separate the poor, the work-shy and the criminal from the insane. And they did so precisely via reference to the moral-psychological state of the latter.

Regardless of what Scull thinks of moral psychology as a science, its categories and techniques were nonetheless built into the cultural institutions that classified, confined and treated the insane population. They were not simply things that went on in people's heads. To treat these psychological categories and techniques simply as ideological misrepresentations of the deviant is to fail to ask a fairly obvious question: Why is it that only particular behaviour patterns - e.g. hallucinations plus laziness rather than mere laziness - show up in the 'inhabited space' of the asylum? If Scull is right that asylums were constructed only to force people to work then all the indolent or recalcitrant would be assigned to them. However, it was only the troublesome with a particular set of 'deviant behaviours' - hallucinations, incoherent speech, trance-like silences - who were defined as insane and relegated to the mental asylum.

In fact, Scull gives no account of the conditions that make a specifically psychological classification and treatment of the insane possible, save the fact that it was doctors who succeeded in cornering the 'service market' presented by the asylum population. This is the line that Scull argues in Section III of the excerpt.

SAQ 13

In section III, why does Scull describe the moral treatment as 'non-medical'? What sort of obstacle does the 'non-medical' character of this therapy pose for the 'medical takeover' of insanity?

For Scull, nineteenth-century 'moral' or psychological treatment is non-medical: (1) because its classification of mental illness involves social norms and values; and (2) because the asylum population that it treats is set apart only by virtue of its deviation from these norms and values. We have just noted that Scull does not explain why this particular population came to be confined and treated specifically as mentally disordered people. It should be clear now that the explanation he offers in section III - that the asylum population is classified and treated as mentally ill because it is a service market captured by doctors - is no adequate solution. Why is it medical psychology and medical practice that succeed in classifying a certain range of behaviours and emotional states under the heading of mental illness? Rather than, say, religion or the prison, which could treat these problems as matters of spiritual or civil discipline? Scull allows no possibility

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for social members - either relatives or the insane themselves - to define and understand a certain set of behaviours with these new criteria, provided by medical psychology, to see these behaviours as afflictions of the moral self or psyche. People who did see mental illness this way were mere dupes of the medical profession.

That individuals did (and do) sometimes find their own emotions and conduct uncontrolled and incomprehensible is indicated by the poem printed at the head of this section of the study guide. Perhaps you might re-read it now. The poem, published in Samuel Tuke's description of his grandfather's Retreat, describes a patient suffering from hypochondria and was written by a fellow sufferer. For Scull, the insane are simply the ultra deviant and for Szasz and Goffman symptoms of insanity are essentially the expression of unpopular ideas or unpalatable conduct. But for the patient in this description, his own feelings and beliefs and those of his fellow patient are deeply disquieting. They are described as an affliction to be rid of so that each can be made 'a man again', that is, so that each can regain control of his 'self'.

In other words, the categories of moral psychology are not simply means for repressing, by misrepresentation, the true nature of individuals who are not really sick. They form part of a system of beliefs and techniques which define and regulate the capacities, conducts and feelings of social agents in terms of a sense of 'self'. The techniques of 'moral treatment' served to form a particular organisation of individual capacities and conducts governed by the moral or psychological self, an organisation which inmates themselves sought and accepted.

Whatever we finally decide about the classificatory categories through which moral psychology treats mental illness, it seems that we cannot simply write them off as ideological misrepresentations of a quite different phenomenon - deviance. However, this does not mean that we will be driven back to Zilboorg and Henry's history of the scientific discovery of the insane and their consequent installation in the norm-free space of the asylum. We have already seen in our discussion of Hempel's attempt to arrive at an objective definition of psychiatric categories that psychiatric observation is irretrievably normative. Here we agree with Scull, Szasz and Goffman. What we need not accept, however, is their assumption that the presence of social norms and values in a category like mental illness makes it an ideological misrepresentation; a translation of purely social differences into a medical rhetoric lacking foundation in historical experience.

Let us re-trace the major turns in the path we have taken through section 3. After introducing the emergence of the new classificatory apparatus (the twin birth of the asylum and medical psychology) for insanity, we looked at the 'progressivist' history of this change. This is a

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history describing the progressive elimination of social norms from the domain of scientific observation. We have also looked at a competing account of these events, one that typifies sociological histories of the birth of psychiatric classification and the asylum. In this history, the asylum population is set apart by the installation of new social norms that result from economically determined changes in the form of work. In the terms of this second history, the asylum is thus born as a means for controlling the socially deviant, and medical psychology with its classification of the mentally ill appears as the ideological misrepresentation of this social fact.

So, where does this leave us? Beyond the apparently mutually exclusive alternatives of science and sociology, we have begun to explore our third option. This is to treat the classification of mental illness as part of the institutions which define and maintain the capacities and conducts of social agents through the 'structural exercises' that produce a 'self'. We will examine the historical emergence of the asylum and medical psychology as parts of this apparatus in sections 4 and 5 of the study guide. But before we do, it might be useful to clarify for ourselves how the psychological self and its afflictions can be at the same time 'socially constructed' yet irreducible to ideology.

3.4 The history of the self

We are now in a position to ask what it is that the categories of psychiatric classification are applied to. This is the question with which Hirst and Woolley open chapter 6 of *Social Relations and Human Attributes*. In reading this chapter through at least twice, pay particular attention to the first two sections (pp.118-125). The question to keep in mind while you are reading is: What is the general picture that Hirst and Woolley paint of the 'self' or 'person' and what is its significance for our inquiry into the object of moral psychology or psychiatry?

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Read chapter 6 in Hirst and Woolley, *Social Relations and Human Attributes*.

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Hirst and Woolley begin by noting that Western forms and concepts of the self or person are by no means universal. This is in sharp contrast with Zilboorg and Henry's assumption that the psychological self names a universal complex of emotions, instincts and consciousness that seems to define human nature as such. But it is quite in keeping with Bourdieu's view of social agency or individuality as a variable organisation of conducts and capacities always dependent on the specific form of cultural institutions.

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Remember that in Bourdieu's description of Berber life, human attributes (e.g. perceptual capacities, characteristic forms of bodily conduct and mental disposition) are not the natural endowment of a self-conscious, self-controlling self. Instead, they are acquired, maintained and regulated by a variety of 'structural exercises' and cultural techniques embodied in institutions like the Berber household. Bourdieu argues that societies can organise the conducts and capacities of social agents through social forms quite unlike our form of the self. If this is the case, then our practice of referring our behaviour to an individual, personal self that functions as a regulating conscience, must - like the Berber practice of referring behaviour to collective, public rituals - be seen as acquired and maintained through definite cultural techniques. The difference is that our Western techniques are individualising whereas Berber techniques are not. In this sense, the individual self is a social artefact, that is, something produced and maintained as an achievement of cultural institutions and practices peculiar to the West; and one way of summarising the position of Hirst and Woolley is to say that it is possible to give a history of Western forms of self. This will be the history of the particular forms in which the conducts and capacities of social agents happen to have been organised via individualising techniques and practices. Hirst and Woolley provide a summary outline of such a history on p.119.

SAQ 14

1. Note down the three stages that Hirst and Woolley isolate in the historical formation of the Western 'self'.

2. What individualising beliefs and practices are developed in the Protestant Reformation and what do they add to the social specification of the self?

According to Hirst and Woolley, the Western 'self' is the outcome of a definite historical organisation of techniques, beliefs and institutions that construct it. It is this organisation which makes the development of psychological knowledges possible, while these knowledges themselves transform the network with the addition of new techniques (the 'moral treatment') and institutions (the asylum). Under these circumstances the norms of psychological functioning involved in psychiatric classification are not given once and for all in human nature (Zilboorg and Henry). Neither are they imposed by the powerful as ideological mystifications of social control (Scull). Instead, norms of psychological functioning are derived from definite individualising techniques and operate in a complex web of institutions and practices that construct the psychological self as a means of forming and reforming social agents.

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SAQ 15

1. What norms of psychological functioning do Hirst and Woolley see medical psychology borrowing from philosophy?

2. Why do Hirst and Woolley say that psychiatry is not just a system of ideas?

If the Western form of the self is constructed by a definite historical set of individualising techniques, practices and institutions, then we should expect to find (as we did in Bourdieu's description of Berber society) that other cultures might organise social agency without imposing a self. This is indeed the general point that Hirst and Woolley make in their description of the Homeric 'soul', a form for specifying social agents from an earlier period of our own culture.

SAQ 16

What is the main difference between the early Greek combination of *psyche, thumos and noos* and our construct of a self-conscious, self-restraining self?

In summary, Hirst and Woolley argue that the psychological 'self' - as the self-conscious, self-governing principle of all our capacities and conducts - is not universal. The norms of psychological functioning used in psychiatry are derived from a distinct historical complex of techniques, practices, beliefs and institutions in which the 'self' has been constructed as a means of organising social agents. Hence, as Hirst and Woolley point out, the norm of consistent self-restrained behaviour will not apply in a culture where conduct is governed by various external agents rather than a self. Equally, it will be impossible to employ psychiatric techniques for diagnosing a moral or psychological interior state when a social agent is not equipped with the techniques of introspection and confession that delineate and construct this inner state.

This account receives an interesting confirmation in empirical field work carried out by psychiatrists treating mental disturbance in African cultures. Reading 9 is an extract from such a study carried out by Robert Collis, a psychiatrist who worked among the Yoruba people of Nigeria.

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Read Robert Collis, 'Physical health and psychiatric disorder in Nigeria' (excerpt), reading 9.

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SAQ 17

List the individualising techniques that Collis sought, but the absence of which obstructed the application of Western psychiatric categories.

Introspection, the construction of stories relating our present mental dispositions to our childhood, the practice of referring mental and emotional states to an interior self rather than external agents: all of these capacities, which we assume as the natural endowment of 'man', are not possessed by the Yoruba men and women. But this does not mean that the self we know via these capacities is a fiction. Hirst and Woolley's account shows us how the psychiatric classification of mental illness can be both 'socially constructed' and yet an inescapable reality for us. This is the observation that opens the door to the third way in which we can investigate the emergence of psychiatric classification. Now we can look at a history of mental illness that is neither a history of its scientific discovery nor of its ideological imposition. Instead we can look at the particular shift in the individualising network that is occasioned by the emergence of medical psychology and the birth of the asylum.

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OF MELANCHOLY.

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OF *THE* METHOD *OF* CURE

Opening of a Vein is seldom to be prescribed to these Patients, whose Distemper proceeds from a low and impoverished State of Blood and animal Spirits; for that will be a means not to raise and enliven, but to enfeeble and sink them by a hurtful Expence.

Vomitive Remedies are generally useful, not only as they empty the Stomach and its Appendages, and carry off their noxious Crudities; but likewise by a strong Concussion, they compel the Glands of the Stomach, the Intestines, and other Organs in the Abdomen, to discharge the peccant Juices that harbour there; and by this means open and unlock their Obstructions, whence they execute their Office as the Oeconomy of Nature requires; but vomitive Remedies are yet farther beneficial, inasmuch as they agitate the Spirits, and by a Counter-motion, give another Turn to their Rotation in one constant Tract; and by that means occasion Diversity of Ideas, and strike out other Roads and ways of Thinking.

Sir Richard Blackmore 1725

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4.1 Preliminaries

It is the conditions of the emergence of mental illness that now provide the focus of our investigation. Our 'history' of mental illness and its classification will be very different from the history of the discovery of an idea or a set of facts. But it will also differ greatly from the history of the imposition of an ideological label. Our task has become quite specific: to describe the transformation of a group of institutions and practices. This is the group that defines and regulates the attributes of individuals by organising a 'self' as their point of referral and control.

We have seen that the self is not a universal means of defining and regulating human attributes. Some cultures achieve this end by means of trans-individual entities like the clan or the totem, or, as we saw in the case of the Berber, the household. We shall now see that eighteenth-century medicine regulated the conduct and demeanour of the insane by a similarly trans-individual entity, the temperament. It was not until medical institutions adopted certain individualising techniques, allowing a psychological self to emerge as a tactic of medical regulation, that mental illness became thinkable.

This orientation we have taken from the French historian Michel Foucault's *Madness and Civilization* and from Hirst and Woolley's *Social Relations and Human Attributes*, whose chapter 9 is an exposition and elaboration of Foucault's book. We will focus on different parts of this chapter on our way through sections 4 and 5 of the study guide.

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Read pp.164-183 of chapter 9 in Hirst and Woolley in order to get a general picture of this orientation.

Now re-read pp.164-167 before answering the following questions.

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SAQ 18

1. Hirst and Woolley describe Foucault's project as an investigation of the conditions under which mental illness 'could become the object of psychiatry'. Why is the metaphor of 'archaeology' used to describe this study rather than the more usual term 'history'?

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SAQ 18 continued

2. It is insisted that psychiatric classification is not the result of the goal-directed development of a knowledge, but is the outcome of a set of undirected changes in social forms and structures that preceded psychiatry. What are the two key areas of change isolated by Hirst and Woolley on p.166?

On the one hand the new classificatory apparatus of psychiatry emerged from the transformation of eighteenth-century medical specifications of health and illness. On the other, it was made possible by the political transformation of the space of general confinement into the specialised therapeutic space of the asylum. These are the lessons of the previous section. Here we will re-work these ideas somewhat to demonstrate the construction of the 'socially informed body' and the reorganisation of its 'inhabited space'.

4.2 The 'socially informed body'

You will remember from section 2.3 that the socially informed body learns its techniques through structural exercises, through doing things rather than thinking about them. Similarly, for Gaub who we are about to study, mental illness and its cures are products more of the body and doing things to the body than they are of the mind. One is trained to be cured through a series of structural exercises.

During the eighteenth century disorders like maria, melancholia, nymphomania, etc. were not the object of an autonomous psychological medicine. Instead, they formed a marginal branch of a general medicine which did not distinguish between mental and physical illnesses in the manner that we now do. Indeed, such disorders were located in the same series as physiological diseases like rabies (originally called hydrophobia), because medical practice diagnosed and treated them according to the theories and techniques of a single medical regime.

The first difficulty that confronts our attempt to understand this regime arises from the fact that it is composed of beliefs, practices, entities and techniques that organise the space of the body and mind (and its relations with the environment) in a quite unfamiliar manner. Chief amongst these are the medicine of fibres, the medicine of spirits and the medicine of humors. As far as possible we will concentrate on the medicine of humors in order to simplify our task.

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The humors, according to the early Greek physician Galen, are the four bodily fluids: blood, phlegm, choler (bile) and melancholy (black bile). These fluids, circulating in the space of the body, do not conform with our current division between physiological and psychological states. (It is interesting that we still call the angry person 'choleric' or even 'full of bile', and the sad one 'melancholic'.) The temperaments are states of the mind and body, derived from the preponderance and combination of particular humors. They are divided into warm or cold and moist or dry. These simple temperaments combine into the four more familiar complex temperaments: choleric (warm and dry), melancholic (cold and dry), phlegmatic (cold and moist) and sanguine (moist and warm). You will be relieved to know that we will not be concerned with the details of this system. What we are concerned to note is that this system permits the character of an individual (conduct, dispositions, demeanour) to be described as the outcome of these bodily and mental agencies; that is, these agencies (humors) are the point of control, rather than some notion of an individual self. For example, the sad or melancholic person is so because of the thickness and heaviness of the melancholic humor that congests the bodily and mental system, impeding the vivacity of feelings and ideas. (Hence the origin of our expression 'heavy-hearted'.) Nonetheless, we shall see in section 4.4 that it is from the transformation of this system that the purely psychological self of psychiatry emerges.

Under these circumstances, with mental and bodily states freely swapping their qualities through the humors (and via the fibres and animal spirits), the solutions to (what are to our eyes) moral and philosophical problems were often located in the medical organisation of the body and its environment. Our second difficulty then, arises from the fact that in eighteenth-century medicine philosophical problems concerning the emotions and perception are not wholly distinct from medical problems concerning the order or disorder of the bodily regime. The disorders of the body and the errors of the mind overlap in a quite unfamiliar way. Melancholy, for example, might be associated with an unshakeable belief in one's own damnation. But this idea is unshakeable quite literally because the thickening of a humor has caused it to stick in corporeal space. It cannot be dislodged therefore by philosophical or psychological means alone but only by techniques addressed to the body and mind simultaneously. So, Sir Richard Blackmore's 'vomitive remedy' for melancholy (printed on the first page of this section) is not only directed at the humoral juices but also at the animal spirits in order to dislodge the fixed ideas of the melancholic character.

In order to clarify these points let us look at reading 10, excerpted from an eighteenth-century treatise on madness *De Regimine Mentis* ('Of The Mental Regimen') by the Dutch physician, Jerome Gaub. The excerpt is divided into two parts. The first is a general introduction in the form of a

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defence of the physician's practice of treating body and mind at the same time and by the same means. The second part illustrates some of the forms of diagnosis and therapy. You should pay particular attention to the way in which Gaub's schema organises the space of the body and mind and situates it in the regulatory domain of the regimen. The regimen is the dietary, social, climatic and geographical circumstances that determine the individual's mode of life.

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Read Jerome Gaub, *De Regimine Mentis* (excerpts), reading 10.

****

In paragraphs 50-59 of section I Gaub is at pains to stress the reciprocal relation of body and mind, while nonetheless distinguishing the physician's treatment of the mind from that of the philosopher. But because body and mind inhabit a common corporeal (bodily) space and are subject to the same regime of 'non-naturals', the distinction that Gaub manages to draw is quite unlike our own.

SAQ 19

1. What are the non-naturals (para.60)?

2. What is the target of the physician's regulation of the non-naturals (para.61 states this connection most clearly)?

The 'mind' that Gaub refers to is quite unlike our 'mind' or consciousness. For Gaub, body and mind are more or less one. A healthy body influences and creates a healthy mind, although the two are seen as a single entity, character or temperament. We live in a world that very clearly separates mind and body. This is sometimes called Descartian dualism from Descartes' statement 'I think, therefore I am'. The mind is seen as a seat of consciousness and of control of the rest of the body. Modern psychiatric techniques, as you will be aware, aim to heal the mind, with the expectation that this will influence secondary bodily effects (e.g. shaking, flushes etc.). For Gaub, the direction, if anything, goes the other way except that this poses a separation of body and mind that he does not conceive. Gaub makes this clear in paragraphs 62-64 where he states that the physician's management of the mind through the body is not essentially concerned with the consciousness or understanding, but with something that he calls character.

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SAQ 20

Briefly summarise the relationship that Gaub posits between mind and body with his notion of temperament.

Through character, the physician intervenes in the conduct, demeanour, and bodily and mental habits of individuals without going through the individualised 'self' of the consciousness. An individual's character may be unique but this is because of the peculiar 'complexion' of the bodily temperaments that results from the individual's regimen. It is not unique because of an individual 'self' which is supposed to be the source of a unique set of experiences. Disorders of the mind and body will show characteristic features precisely because each disorder is specified in terms of the combination of a limited number of extra-personal agencies (the humors and passions) and their relations to a mode of life. In treating mental disorder Gaub does not treat the self of the patient but his character; that is, a particular organisation of conduct, demeanour and habits linked to a way of life by the bodily temperament. The object of the treatment is at once bodily and mental. It concerns the physical well-being of individuals and their moral organisation (which links them to the world via perceptual and emotional states) at the same time.

The degree to which the eighteenth-century construction of character cuts across our division of body and mind can be gathered from the treatment of the emotions. The emotions are at once affective states, arising in the mind, and bodily states, determined by the action of the humoral fluids. As such, emotions come and go, are quiet or rebellious, depending on the complexion of the temperament established by the regimen and are quite independent of a controlling self. Eighteenth-century character disorders in fact indicate imbalances in bodily temperament brought about by errors in mode of life, rather than the failure of a self to control its behaviour and emotions. For this reason emotional disorders are not treated by reinforcing the self but by techniques acting directly on the regimen and temperaments that determine character.

In order to clarify this difference let us look at Gaub's specification and treatment of mental disorders in section II of the excerpt.

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Re-read section II of Gaub, reading 1G.

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The fact that the humoral schema permits the free exchange of bodily and mental qualities makes the passions and emotions central to Gaub's treatment of madness. Emotions like joy, fear and anger can arise in the mind, or rather from its *enormon* or power of arousal. Passions like pain and anxiety on the other hand, can arise from the body and its enormon. The passions and emotions have a privileged place in the description of madness because they produce a disturbance that can be transmitted from mind to body or from body to mind, or to both simultaneously. For this reason the eighteenth-century passions differ in scope, location and effects from our emotions.

SAQ 21

Why is Canus Julius not anxious at his approaching death? How, according to Gaub, could he have been made anxious?

The fact that eighteenth-century treatments of madness accord a privileged place to the passions should not therefore be taken as a sign that they had a psychological object. The passions mark a point prior to the division of body and mind from which both can be affected depending on the imbalance of the temperament brought about by errors in mode of life. They are the fulcrum on which the individual character (i.e., the conduct, demeanour, etc.) sits, always moving between balance and imbalance, temperance and intemperance, depending on the management of the non-naturals. Hence, if eighteenth-century madness is not 'mental' then it is not a purely physical pathology or 'illness' in our sense either.

Since Descartes in the seventeenth century, European philosophy had given the mind power to control the passions in relation to conduct. We have seen that this is not the case in medicine. Gaub's 'mind' is not Descartes' self-conscious, self-controlling seat of awareness, capable of unifying in consciousness all the other conducts and emotional states of the individual. Instead, the mind and body of eighteenth-century medicine inhabit a single field organised by the schema of the humors. This field - the character or temperament - is thoroughly penetrated by the passions which link variations in mode of life to variations in behaviour and perception without going through the 'self' or consciousness. For this reason eighteenth-century madness is not subject to the same norms of self-restraint and personal responsibility for conduct that governs the nineteenth-century classification of mental illness.

You will notice in paragraph 15 that Gaub does not 'blame' people for not resisting the humors, the effects of bodily imbalance and shock, in the same way that we would. He considers it perfectly natural that the body will

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sometimes overwhelm the resistance of the mind. Thus pregnant women driven to homicide and cannibalism, the inheritance of thieving tendencies from the father or vice from a wet-nurse are all explained as irresistible effects of changes to the body. As such, the perpetrators of these actions are not to be held responsible, or to be held able to do something else in response to these physical intrusions.

So, according to Gaub ...

> it is no longer possible for anyone to doubt that, in general, there are agencies apparently having the power of acting on the body alone but capable of bringing about tremendous changes in the mind as well, ...

These agencies, pre-eminently the passions, act independently of the conscious understanding and transmit disturbances to the mind and body without favour. For this reason a passion inflamed by wrong diet or made melancholy by isolation and immobility can just as easily poison a wet-nurse's milk, causing bodily harm, as lead to a fixation of ideas causing tal harm. Hence, all the physician's interventions must be calculated in terms of the temperament or character, that point of linkage between body and mind and mode of life. And it is from here that the specific character of eighteenth-century treatments of madness arises.

SAQ 22

Gaub discusses the treatment of mental disorders in paragraphs 93-96. Bearing in mind our earlier discussion of anxiety, what is it that distinguishes submersion therapy from a purely psychological therapy?

The object of the medical treatment of madness or unreason is not to put the self and its understanding in command. Rather it is to directly modify conduct and perception, or demeanour and emotional state, transforming the temperament in which they are located by a judicious management of the 'non-naturals'. As a result, apparently physiological remedies like the 'vomitive' described by Blackmore may be aimed at modifying perceptual and emotional states while the employment of an apparently psychological technique like submersion therapy is, in fact, directed towards arousing anxiety in the body.

Finally, these schemes and treatments cannot be reduced to Zilboorg and Henry's portrait of them as an absurd theory of the physiological causes of madness. (Gaub is quite aware that his treatment operates independently of a

knowledge of bodily causes.) They are not simply quaint ideas but norms, practices and techniques that constituted practical 'structural exercises' for the 'socially informed body', as the following diary entry from *Boswell's London Journal 1762-1763* shows:

> Friday 6 May [1763]. I awaked as usual heavy, confused, and splenetic. Every morning this is the case with me. Dempster prescribed to me to cut two or three brisk capers round the room, which I did, and found attended with most agreeable effects. It expelled the phlegm from my heart, gave my blood a free circulation, and my spirits a brisk flow; so that I was all at once made happy. I must remember this and practice it. (Pottle, 1950, p.253)

In other words, the absence in the eighteenth century of an autonomous medical psychology taking as its object a purely mental disease is not the sign of a failure to observe and classify the symptoms of mental illness. Instead, it signifies that the individual 'psychology' and its disorders had not yet emerged as the target of a set of techniques designed to regulate character by individualising a 'self'. As long as the conduct, demeanour and capacities of the character could be regulated directly by techniques aimed at the body and mind simultaneously, character disturbances (i.e., madness) could not be the object of psychiatric classification and treatment.

When the psychological self and its afflictions do show up at the end of the eighteenth century it is not because scientific observation has uncovered an eternal fact or discovered a natural division in the 'confused' space of general confinement. Rather, it is because the schemas and practices of eighteenth-century medicine are themselves transformed by the intervention of individualising techniques derived from religion and philosophy. The psychological self is constructed by these practices, not uncovered by the stripping away of prejudices. We will discuss this transformation in section 4.4.

4.3 The structure of 'inhabited space'

In this section we will consider the emergence of the mental asylum in terms of the structure of inhabited space it represents. Recall that in section 5 of Course HPC1b, *Traditions*, you looked at a number of definitions of 'institution'. You might remind yourself of these by turning to p.47 of that study guide, if you have it handy. Here the term is construed quite broadly as applying to 'any organised element of society' and includes both organisations of concepts and practices, in no particular order of privilege.

There is a good reason for not dividing institutional space between the mental and the material, or between a

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domain of thoughts and perceptions and a domain of economic practices and functions. This becomes clear if you recall Bourdieu's description of the Berber household. The Berber household overlaps the formation of sexual attributes (the modesty of women, their confinement to the house and the kitchen in particular) and the formation of economic capacities (the domestic skills of women, the skills of the field for men). We cannot separate a 'symbolic' and a 'technical' side of this overlap. The house as social space is organised by a variety of practices and techniques - sexual, economic, cultural etc. - in no particular rank order. It is this organisation that transforms the house into a socially charged field where the perception and the characteristics of social agents are formed and maintained.

We can treat the institutional space of eighteenth-century confinement in a similar manner. Hirst and Woolley do so on pp.172-175 of *Social Relations and Human Attributes*. But because they contrast eighteenth-century confinement with the relative liberty of madness during the Middle Ages and Renaissance you may find it useful to quickly re-read pp.168-172 as well.

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Now re-read the section called 'The Great Confinement', pp.172-175.

****

In Hirst and Woolley's exposition it is not so much the crisis of beggary and vagabondage that is important as the response to it. This took the form of a new system of public administrative supervision and control based on the houses of correction. You will recall Donnelly's description of the network of prisons, work-houses and bridewells that performed this function in England. This system represents the formation of a new structure of 'inhabited space' and a new social classification for the exclusion of 'marginal classes'.

SAQ 23

What common feature do the confined groups share?

The character of the system of confinement, and hence of the response to social and economic crisis, is determined by a variety of factors according to Hirst and Woolley. One of these is the specific history of the architectural space used for confinement.

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SAQ 24

What significance do the writers attribute to the fact that the system of confinement took over the old leper houses (lazar houses)?

A second and more important factor in the organisation of the space of confinement is the role of religious beliefs and practices.

SAQ 25

The demand to labour does not have a solely economic determination. What is its other basis and how does this affect our understanding of work as it was conceived at this time?

In Hirst and Woolley's exposition the fact that labour is a religious as well as an economic practice transforms the boundary drawn around those who do not work into a moral division of social space. This division has decisive effects on the grouping and perception of its inhabitants, particularly the mad. Michel Foucault takes up this theme in reading 11.

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Read Michel Foucault, *Mental Illness and Psychology* (excerpt), reading 11.

****

SAQ 26

Foucault describes the effects of this restructuring of the space in which madness is socially specified as 'doubly important' (second paragraph of reading).

Describe the double effect isolated by Foucault.

The space in which insanity shows up is bounded by the failure to labour. This failure is at once moral and economic because work has the role both of a religious discipline and a 'structural exercise' organising the

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individual's capacities and perception. (Remember Hirst and Woolley's remark (on p.120) that at this time religion is not just a set of ideas about the other world but a set of techniques and practices constructing social agents in this one.) The insane are not confined because they are sick and in need of therapy. What counts as insanity at this time is determined by the social and moral dereliction of idleness, so that confinement is the space of common exclusion inhabited by all those who do not engage in a particular religio-economic practice, labour.

We can conclude that nothing about the organisation of confinement shows that insanity had to become a medical problem, rather than a problem of religious discipline (as it is in some cultures) or of social welfare. While it is true that the insane were initially picked out as part of a larger group who were unwilling to labour, this was not the 'essence' or defining characteristic of everyone in that group. Very quickly the conditions for selecting that group changed to incorporate a notion of social incapacity. As these conditions changed, the definition of insanity changed and the insane became a quite distinct group from all other 'misfits' and 'undesirables'. For Scull, all the incarcerated always were and still are the economically deviant. There is no such thing as a separate group who are constituted, defined, and treated as mentally ill in Scull's register.

Let us summarise the results of our inquiry into the structure of 'inhabited space' represented by eighteenth-century general confinement. The common internment of beggars, vagabonds, the criminal and the insane was not the result of a confusion in the eighteenth-century medical mind brought about by the presence of social norms in medical observation (Zilboorg's and Henry's position). But neither can we conclude that the insane essentially belong in this larger population, on the grounds that all its members share the common characteristic of economic deviance (Scull's position). General confinement was a historical division of social space, organised in particular by the economic and religious discipline of labour. Here, the insane were specified by their social and moral exclusion, along with the idle and footloose, the scandalous and poverty-stricken. When the mentally ill are isolated in this (as it appears to us) motley collection, it is not because their essentially medical symptoms have been observed and classified for the first time by the penetrating and humane gaze of a Tuke or a Pinel. Neither is it the result of labelling the refusal to work as deviance because of the needs of capitalism. Rather, it is that the structure of social space represented by eighteenth-century general confinement is itself broken down and reorganised. And it is in this reorganisation that a therapeutic space is formed, dividing and characterising forms of individuality in a quite new way and making the classification of mental illness possible.

However, as we have anticipated in section 4.2, this therapeutic transformation of the structure of 'inhabited

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space' is jointly conditioned by a change in the form of the medical treatment of the 'socially informed body'. Crucially, the system of confinement had produced the conditions or formed the surface on which madness would show up as a condition to be excluded for its social and moral dereliction. But the group of norms and techniques that would permit madness as a moral failure to be treated in terms of a medical disorder were being formed elsewhere, we have seen, in the transformation of medical knowledge. In other words, the isolation of the insane is not the result of the exercise of scientific observation but, as we shall soon see, of a series of social and political changes. Meanwhile, the transformation of eighteenth-century treatments of character disorders (that would soon permit the treatment of disorders of a psychological self) was going on in 'private practice', quite independently of the confined insane who were not treated as sick. The order of confinement and the techniques of medicine are not linked by a necessary relation - like perception or discovery - but by the contingent or accidental relation that arises when different institutions and practices join the same historical group. Before going on to describe the results of this shift, we must look at the historical circumstances that made it possible for the institutions of confinement and the medicine of madness to overlap in a single historical complex or apparatus.

4.4 The moral regime

We have seen that eighteenth-century 'hospitals' were not places of therapy but places in which the insane were interned as part of the process of moral and social exclusion and 'correction'. Changes in the specification of insanity were occurring in the non-hospital domain of medical practice. These are the changes that eventually made it possible to classify madness as a purely psychological disorder. Hirst and Woolley summarise Foucault's account of this shift on pp.175-177. You have already looked at this passage in section 3.1, but you will probably find it helpful to re-read it now in the light of the understanding of eighteenth-century medical knowledge of insanity that we have gained from Gaub's treatise on the mental regimen.

The treatment of body and mind as a single system and the administering of cures directly to the bodily temperament, rather than the controlling mind, led to these sorts of recommendations; for example, advice from Blackmore on the treatment of melancholy:

> Copious eating of apples has been to some very serviceable; and the benefit of agreeable diversions, especially riding on horseback, new company, change of place, and variety of objects, that recreate the spirits and give them another turn, is known so well to all, that I have only named them. (Blackmore, 1725, p.174)

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But, as Hirst and Woolley record on p.176, changes were taking place in medical practice which would radically sever vomits and apple eating from the sorts of treatment that regulate company and amusements. These changes, which lead to the characterisation of purely mental illnesses, take place in the treatment of diseases of the nerves and in the conception of sensibility. A detailed description of this process is unnecessary for our purposes. If you have the time and interest you can read such a description in chapter 5 of Foucault's *Madness and Civilization*, listed in the further reading list.

Hysteria provides an appropriate example of this. From the time of the Greeks until the seventeenth century, it was recognised as a bodily illness. It was originally thought to be the result of the womb moving (note how even then it was associated with women) and was called 'the rising mother'. However, the particular aspect of hysteria relevant for our purposes is that it could appear in any part of the body and take on the symptoms of any other disease. Because of its ability to appear anywhere, hysteria was more amenable to a redefinition of bodily illness to moral failure. The cause of hysteria was redefined in the eighteenth century as the body's lack of resistance to sensation and passions. Lack of resistance thus becomes a moral failure to resist, because the disturbance is now admitted through a moral weakness or indulgence rather than by a direct modification of bodily temperament.

Second, eighteenth-century medicine had included in a single space the individual's feelings or disposition (his or her 'sensibility') and the physical movement of sensations in the nerve fibres. In this way states of feeling and dispositions (e.g. irritability) were continuous with bodily states (physical irritation of the fibres). This was to change also. The capacity to feel was gradually parted from the physical movements of the fibres, sensibility detached from sensation. The result is that 'diseases of the nerves' are less and less attributed to bodily changes (as in Gaub's description of anxiety) and more and more to a moral tendency to feel too much. Sensibility is thus detached from the body and becomes a purely moral or 'psychological' avenue of disturbance.

Through this series of changes medical practice began to characterise madness in terms of a moral failure to resist sensations and passions, and in terms of an excess of feeling that connected one too immediately to the world. Therapeutic techniques like immersion, purging, change of scene, etc. could no longer be aimed at the bodily quality of the temperament or character because disorder was increasingly invested in moral weakness and delicacy of feeling. This meant that the old techniques took on a new role, that of punishment and reward aimed at restoring the moral resistance and self-restraint of a 'self'. In other words, a purely mental illness became possible only once the

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old intemperances were translated from errors (in diet etc.) to signs of moral weakness and guilt.

Foucault describes this point of transition in part I of reading 12.

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Read part I, Michel Foucault, *Madness and Civilization* (excerpts), reading 12.

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Now answer the following questions which will help you to focus the shift from the eighteenth-century medicine of madness to nineteenth-century psychiatry.

SAQ 27

1. Why does Foucault say that eighteenth-century 'music therapy', which appears psychological to us, is not so?

2. Describe the indications of the change that separates moral from physical treatments. What is it that allows eighteenth-century therapies to take on the function of punishment?

The shift that Foucault discusses is to a practice that regulates by employing individualising techniques aimed at producing a responsible subject. In other words, the psyche of psychiatry is constructed not discovered. However, if towards the end of the eighteenth century it was becoming possible to conceive of madness as a mental illness, there was as yet no such thing as a discrete and separated population of the mentally ill on which an emerging medical psychology could exercise its knowledge. The insane population was not divided off from the rest of the confined population by the advance of medical knowledge but by changes in the social space of confinement. Let us look at these.

They occurred not because of the intervention of medical definitions but because of a set of social and political forces that change the form in which confinement divides up social space. Hirst and Woolley outline Foucault's account of these forces on pp.177-178.

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Read Hirst and Woolley, *Social Relations and Human Attributes*, pp.177-178.

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Hirst and Woolley isolate three factors in Foucault's description of the reorganisation of confinement: the political criticism of confinement as an abuse of monarchical power; the economic rejection of confinement as a solution to the problems of poverty; and a reform of penal methods. Let us look at Foucault's account of the first two factors in part II of reading 12.

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Read part II of Michel Foucault's *Madness and Civilization* (excerpts), reading 12, and then answer the following questions.

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SAQ 28

1. In a short paragraph explain why Foucault says: 'No medical advance, no humanitarian approach was responsible for the fact that the mad were gradually isolated ...' (R12:3).

2. We have seen that for most of the eighteenth century idleness and poverty had been treated as signs of social and moral transgression warranting exclusion. In what way does the perception of poverty and idleness change towards the end of the century and what are the conditions permitting this change?

In Foucault's account, madness becomes a visible 'social problem' at the end of the eighteenth century because the social space in which it had previously been characterised and excluded was breaking down. The single space into which the economic and religious injunction to labour had ejected all those who did not work was fragmenting. Idleness and poverty in particular could no longer simply be equated with moral dereliction because manufacturing industry treated them as a resource or pool of labour to be drawn on when needed. They now represented a population to be maintained rather than excluded. The insane population was left out of this division into a series of new spaces - penality, therapy, social and family welfare. Hence, the insane were left isolated as the conspicuous remnant of confinement.

So, the situation at the end of the eighteenth century looked something like this. The transformation of medical

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practice had produced a set of techniques aimed at regulating behaviour and disposition through the construction of a purely psychological or moral 'self'; but these techniques were not addressed to a hospitalised population. Changes in the structure of confinement on the other hand, had isolated an insane population without providing it with definite forms of regulation or treatment. However, there was a point at which these two discrete orders of change overlapped. The breakdown of the space of confinement had isolated the criminal and insane populations as the last inhabitants of the old space of moral exclusion and social guilt. The transformation of medical practice had, for its part, produced a set of techniques aimed at forming a self that was responsible for all its thoughts and actions by producing a morally constraining disciplinary environment. At this point then, an emergent medical psychology could enter the space of confinement by transforming it into the morally therapeutic space of the asylum. It is to this we turn in the next section.

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TRAGEDY LINGERS ON

LOS ANGELES (AAP-AP). - A policeman who shot a five-year-old boy to death after mistaking the child's toy gun for a real one has been placed in a sanitarium, The Los Angeles Times reported yesterday.

A close family friend told the newspaper that officer Anthony Sperl, 24, of Stanton, initially sought consolation from his family's parish priest after Patrick Mason was shot inside a dark apartment on March 3.

Sperl's moods varied from highs of non-stop talking and pacing to lows of silent brooding, the friend said. When Sperl eventually spoke to a psychiatrist about the incident, he began having nightmares.

The officer lapsed into a deep, silent depression and, on the advice of his psychiatrist, entered a private hospital for the emotionally disturbed.

Sperl had been investigating a report that the child and his mother, Patricia Ridge, 29, had not been seen in 10 days. The boy was left alone in the apartment while his mother worked because she said she could not afford day care. Because the apartment was sparsely furnished, Sperl thought it might have been burglarised or vacated, police said.

He heard a noise, kicked open a door, saw a figure holding a gun and opened fire. Patrick was hit in the neck.

Courier-Mail, 6 April, 1983

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5.1 Introduction

We have seen how political and social changes in the organisation of confinement left the insane isolated as a morally disordered population. Elsewhere, in non-hospital medical practice, a different series of changes had robbed madness of its bodily home. This moralisation of mental illness can be treated as a specific instance of the process of individualisation discussed by Hirst and Woolley (section 3.4 above). Madness was transformed from a problem of temperament (the humors affecting the mind and body) to a problem of will or conscience, a moral problem. These two disconnected developments overlapped in a particular space, the space of the asylum re-invented at the beginning of the nineteenth century as a morally regulating environment. The emergence of psychiatric classification at this time and place was not because that population had always been mentally ill (Zilboorg and Henry). Nor was it because the population lacked the power to resist ideological classification by more powerful doctors (Scull). Rather it was because, according to Foucault, the twin emergence of moral psychology and the separated population of the insane made psychiatric classification an inescapable but historically grounded reality.

In section 5 then, we focus our attention on the circumstances in which the object of psychiatric classification first appeared in the new moral landscape of the asylum.

5.2 Moral methods

According to their proponents, the moral methods of early nineteenth-century medical psychology were 'moral' in two senses. First, because they were more humane than the brutality and physical restraints of eighteenth-century confinement, and second, because they were not physical remedies aimed (like Gaub's) at the patient's bodily temperament, but were psychological techniques aimed at a principle of moral control, the 'self'. But, without wishing to deny the fact of improved conditions and treatment, these claims cannot be taken at face value for two reasons:

1. We have seen that the moral methods are not self-evidently more humane: eighteenth-century madmen were confined as brutes not as the result of arbitrary cruelty, but because it was believed that absence of reason reduced man to bestiality not sickness.

2. Psychological techniques are not necessarily more true to human nature: eighteenth-century medicine could regulate conduct and demeanour quite successfully by managing the regimen and without individualising a purely psychological self.

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Those of us steeped in scientific classifications of the world will probably find this hard to accept. The point is that both illness and cure are defined and limited by the approaches taken to them.

What we are dealing with in the moral methods is not a change in ideas of madness, but in the conditions that make it possible as the object of medical regulation. Hirst and Woolley help us to develop this point.

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Read Hirst and Woolley, *Social Relations and Human Attributes*, pp.178-183.

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SAQ 29

Summarising Foucault, Hirst and Woolley state on pp.179-180 that the difference between Tuke's and Pinel's religious and philosophical ideas is insignificant when compared with the reorganisation of institutional space that is common to both. Describe the common features of this reorganisation in a short paragraph.

The transformation of eighteenth-century treatments of 'diseases of the nerves' had not provided a theory of mental illness but a set of techniques, norms and practices. We have seen that medical practice gradually made madness psychological by shifting disturbances in conduct from their bodily sources and by tying them, instead, to a failure to resist moral influences. Hence, the 'discovery' of the psychological self is not the result of a theoretical advance but of an adaptation of techniques and norms (largely borrowed from religious and philosophical 'exercises') aimed at establishing the self and self-control.

This can be gathered from Samuel Tuke's description of his grandfather's famous asylum, the Retreat, which was the first psychiatric asylum in England. Part I of reading 13 is an excerpt describing the adoption of moral (i.e., psychological) methods.

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Read part 1 of Samuel Tuke, *Description of the Retreat* (excerpts), reading 13.

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SAQ 30

1. Paraphrase Tuke's attitude on whether the causes of insanity are mental or physical and on the use of drugs in its treatment (R13:1).

2. Both Gaub (R10:10) and Tuke employ techniques for arousing fear as a cure for madness. In what ways do their cures differ?

Fear is not directed at the body and mind of the patient in order to regulate conduct by directly modifying its 'qualities'. Instead, the object is to get the patient to regulate his or her own conduct by internalising norms that result in a conscience or self. This enables us to see that a central feature of the moral methods is their capacity to function as techniques of observation for both doctors and patients. Both patient and doctor derive a capacity for observing madness from the asylum's capacity to function as a type of 'moral mirror'. But this is not a sign - as Szasz, Goffman and Scull would have it - of the distortion of a given medical observation by social norms and values. The patient's view of his or her conduct is limited and defined by the organisation of the retreat. These activities define illness and construct its cure - which the patient learns to recognise. The patient only sees his or her conduct insofar as it conforms to or transgresses the moral organisation of the institution. This means that both observation and classification are themselves normalising or curative, constituting the very core of psychiatric practice. Let us explore this point in a little more detail.

5.3 Normalising observation

We have seen how the otherwise unrelated spheres of the medical regulation of self and the social confinement of the insane came to overlap in the formation of a morally therapeutic space.

The resulting space of the asylum then, is not just one in which insanity shows up in the moral landscape formed by family, church, law and occupation. It is also one in which this landscape is 'medicalised', i.e., it becomes an object, ultimately, for specifically medical treatment. The self in any one of these social domains is never far removed from its psychiatric characterisation. Connected on the one side to the institutions in which social attributes are formed and maintained and on the other to techniques of medical management, the asylum is both social and medical. The asylum redefines social incapacities as failures of the

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psychological self. It also provides these incapacities with a point of medical reference. The discipline of psychiatry thus bestows a new centrality on the psychological self by permitting a whole range of incapacities and misdemeanours to be specified as psychological problems that are, in principle, rectifiable through medical attention.

Part II of reading 13 illustrates the mechanisms through which the failures of the self are made observable in the 'inhabited space' of the asylum.

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Read part II of Samuel Tuke, *Description of the Retreat* (excerpts), reading 13.

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SAQ 31

1. List some of the norms and practices of other social institutions that are embodied in the asylum.

2. Tuke describes the giving of tea parties as contributing to the patients' comfort and their cure. In what way does the ritual of the tea party constitute a technique of observation? How does this technique itself function as a therapy?

In SAQ 29 of Course HP03a, *Community and Identity*, you were asked why the 'interpretative scheme' of the asylum is a moral one. You may like to consider this again: Why is the observation of mental illness organised by Tuke's asylum necessarily a moral one? For Tuke's asylum, psychiatric observation is moral because it results from definite social practices (like the tea party) which embody norms of appropriate conduct and which form the backdrop against which mental illness shows up. These 'character forming' institutions from outside the asylum are normative. Goffman, on the other hand, argues that the interpretive scheme of the asylum is moral because it is based on a theory of human nature employed by the staff in order to impose their views on the patients. According to Goffman, the normativity of observation and treatment is the result of the moral and theoretical predilections of the staff. We will take up this difference briefly in section 6.

Work therapy, religious therapy, the therapy of social rituals like the tea party, all provide the patient with norms and techniques for observing his or her own conduct as conforming or transgressing. In this way they permit the internalisation of a principle of control, the self, as the

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means of maintaining and regulating various social capacities. On the other hand, the asylum provides a new division of social space in which certain breakdowns of conduct and demeanour and certain conflicts between social norms will be defined and treated as psychological illnesses. Hence it would be just as correct to describe psychiatric classification in terms of the presence of medical norms in the social sphere as in terms of the presence of social norms in the medical sphere.

This point is borne out in the case of the unfortunate policeman described on the title page of this section.

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Re-read 'Tragedy Lingers On' (p.72) now.

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Here we are confronted with a case in which the conflict between norms of expected conduct (those of parent and policeman) produces a breakdown in the control of demeanour which is experienced by the family and the individual concerned as an illness. (Although not before the policeman has attempted to treat it as a problem of spiritual discipline.) Psychiatric classification then, not only concerns the means by which institutions specify norms for individual functioning. It also involves the means by which an individual perceives and maintains his or her deepest self. The fact that this self is no deeper than the 'surface' of norms and practices on which the individual observes his or her behaviour does not mean, however, that it can be dispensed with as an ideological image.

A ritual practice like the tea party organises a capacity for observing conduct and demeanour which is at the same time a technique for normalising them. (This technique permits an individual to perceive his or her emotions and behaviours as approximating or deviating from norms of conduct which, because they go to make up a self-restraining self, are also a means of normalising conduct and disposition.) In other words, psychiatric classifications of states of the self are neither accurate nor inaccurate, neither reliable nor unreliable as Hempel understands these terms. Instead, they relate behaviour to the process of normalisation. Cures can thus be effected without conventional medical interventions (e.g. drugs, surgery) purely by modifying the 'techniques of the self' that enable individuals to monitor and regulate their behaviour, emotions and perceptions. We can develop this point by investigating the form of doctor-patient relation that the asylum makes possible.

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5.4 The doctor and the patient

It is striking that nowhere in Gaub's descriptions of his treatment of character disorders is there any evidence of an attempt to get to know the patient as a 'person'. We have seen that the self is not the object of eighteenth-century treatments of madness. Gaub treats the corporeal temperament directly and in so doing modifies intemperate behaviour and emotions without locating their cause or cure in a purely mental self or personality. By the time of Tuke and Pinel, however, the classification and cure of insanity are inseparable from the form in which the doctor knows the patient's innermost self.

The organisation of the asylum, in which the patient recognises his or her disorder against the desirable order of a moral regime and was cured when this regime was internalised as a regulatory conscience, permits a new relation between doctor and patient. On the one hand, the doctor embodies all the social norms and authority invested in the asylum. He is thereby qualified as a model self in whom the madman and madwoman see their own conduct reflected and find it automatically judged and censured. On the other hand, the doctor is the point at which all the rituals and techniques of observation and normalisation seem to look back at the patient and, in looking, transform and restrain. No doubt this explains the curious power attributed to the doctor's gaze in Pinel's description of the governor and governess of the Bicetre asylum.

In Pinel's description we can discern the way in which social and moral norms are embodied in the relation between doctor and patient, which forms the specific mechanism by which mental illness is known and cured.

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Read Philippe Pinel, *A Treatise on Insanity* (excerpt), reading 14.

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SAQ 32

1. What is the lesson of Pinel's story of the aristocratic madman? (R14:1, Footnote x). What light does it shed on the therapeutic role of the doctor's authority?

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SAQ 32 continued

2. Read the cases of the bereaved son and the ruined father, underlining their common features.

   (a) List some of the norms of conduct and demeanour (e.g. in relation to aggression, speech etc.) which, when deviated from, signify insanity.

   (b) In a short paragraph describe some of the ways in which the knowledge and cure of insanity are determined by the relationship between doctor and patient.

The doctor's knowledge of the patient's character or self becomes the condition of cure, but not because this self is the private source of all the patient's behaviour, emotions and perceptions. Rather, the patient's self is the public result of a whole range of techniques that internalise self-regulation. It is these techniques that are concentrated in the doctor-patient relation. In the doctor the patients recognise themselves in the image of the rational self-governing individuals that they must become. The doctor's observation of the patient is itself wholly organised by normalising spectacles (such as the tea party) that establish physical and perceptual boundaries in the 'inhabited space' of the asylum.

So, this third view of mental illness would agree with Goffman that asylum practice seems to involve some sort of implicit 'theory of human nature'; but disagree insofar as he treats this as a set of ideas that one group of individuals (the staff) have about how another group (the patients) should behave. We have discovered instead that norms of conduct etc. are embedded in a variety of normalising practices (like Tuke's tea parties, work therapy, the ward system etc.). These constitute the heart of the morally therapeutic environment formed when the medical regulation of the self entered the institutions of confinement. They apply to both patients and doctors because they do not originate in either but in the new institutional environment that makes the doctor-patient relation possible. This new environment conditions both the behaviour and roles of the doctor and the patient. To some extent, Goffman perceives this in his analysis of the staff world. The staff, too, are bound by limitations (managing the patients) and practices (of curing) that they cannot abandon. Becoming 'normal' is (re)learning the exercises (or behaviours) of selves outside the asylum.

We have seen that these therapeutic techniques provide a focus for a much larger network of norms and practices (located in the family, religious and legal institutions,

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etc.) in which individual attributes are maintained by inculcating a self as their principle of regulation. The tea party and work therapy concentrate a whole array of observational and normalising techniques precisely because, outside the asylum, they form part of a network of institutions in which manners and conduct are inculcated and regular habits formed. In this regard they are directly comparable with the 'structural exercises' described by Bourdieu. Indeed, in these 'techniques of the self' we are isolating part of the system that specifies and maintains our 'socially informed bodies'.

The doctor-patient relation is one point at which this complex regulatory system based in the clinical organisation of the asylum is embodied in individuals. Far from being seen simply as a relation between persons, it is a relation in which the personal attributes of doctor and patient are formed and regulated independently of their 'selves'. Their 'selves', in fact, can be considered the result of the process.

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Re-read Pinel's character sketch description of the personal qualities of the governor, R14:3-4.

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SAQ 33

1. Paraphrase this character sketch.

2. Does Pinel feel his formal medical knowledge is as useful as the qualities of the person of the governor?

Szasz, Goffman and Scull are justified in saying that the psychiatrist's status and curative power do not derive from a specific medical theory of insanity. But it does not follow from this that his status derives from a purely social power, used to enforce arbitrary norms of behaviour (disguised as medical norms) on a population that is not really ill. The norms of individual functioning built into the asylum are not arbitrary, but embodied in a range of techniques and practices that organise individual attributes around the formation of a responsible and self-regulating self. In this way, medical knowledge of mental illness is inseparable from the enforcement of social norms of self-regulation. The fact that since the late-eighteenth century certain disorders of individual conduct and feeling have been understood as a peculiar type of medical complaint is, therefore, not a subterfuge of those in power, but an inescapable cultural fact. (This is the lesson that we learn from Tuke's hypochondriac poet and from our unfortunate Los Angeles policeman.)

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That the doctor's curative power is both medical and moral, that it depends on a therapy inseparable from the activation of social discipline - these are signs that the doctor entered the asylum as a new curative personage, emerging from the overlap of medical knowledge and social discipline permitted by the asylum. Foucault develops this point in reading 15.

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Read Michel Foucault, *Madness and Civilization* (excerpt), reading 15 and then answer the following questions.

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SAQ 34

1. According to Foucault, from what sources does the psychiatrist derive his curative power?

2. The psychiatrist is described not as a scientist but as a personality. What are the chief characteristics of this personality and from where do they derive?

3. What were the indications that the seventeen-year old girl required a cure? What was Pinel able to do to observe these conditions and bring about the cure?

Psychiatry's therapeutic power is therefore based not in a scientific theory but in the social norms invested in the curative personality of the doctor. The asylum is a form of 'inhabited space' penetrated by all the norms, disciplinary techniques (like confession) and institutions (like the family) that organise individual attributes around a self. Psychiatry borrows the moral tactic of the confession but at the same time moves beyond the asylum to organise people's perceptions at school, in the church or family. There is a relay or exchange, both a psychiatrisation of everyday life and a borrowing of the individualising techniques of moral life by the asylum. The way in which the policeman could turn so quickly from priest to psychiatrist shows how thoroughly psychiatric categories saturate our forms of social and moral discipline. Psychiatry is thus able to define the social threshold beyond which uncontrollable conduct will be understood as a mental disorder, even by the individual concerned. This interpenetration of psychiatry and society has two consequences concerning the knowledge provided by the discipline of psychiatry. First, it suggests that psychiatry does not obey the law that puts correct knowledge and the enforcement of social norms on opposite sides of the fence. Second, it shows that psychiatry does not obey a sociological law that puts self knowledge and institutional regulation on opposite sides of

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another fence. We have seen that psychiatry and the asylum cut across both these boundaries. In so doing they constitute what Foucault calls a disciplinary knowledge, that is, an apparatus in which power is exercised not by one group at the expense of another but through the forms in which individuals are known and know themselves.

We shall, in fact, conclude our inquiry into classification by looking at psychiatry as a disciplinary knowledge.

TUTORIAL TWO

Your answers to SAQs 31 and 32 provide the basis for this tutorial discussion, so you should bring them along as well as the associated readings.

We began the course with a picture of classification as a general relation between the natural characteristics of classes of objects and the universal capacities of observation and conceptualisation supposedly possessed by individuals. This was a relation which, it was alleged by Hempel and by Zilboorg and Henry, could be made scientific by eliminating social norms from the process of observation.

1. How does the psychiatric observation and classification of mental illness described by Tuke and Pinel differ from this initial picture of classification?

2. How do asylum practices (work therapy, the tea party etc.) function as definite techniques of psychiatric observation?

3. Can psychiatry have the goal of eliminating social norms and values from the processes of psychiatric classification?

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6 CONCLUSION: DISCIPLINES AND DISCIPLINARITY

Our picture of classification has changed rather dramatically on our way through the course. We began by looking at classifications as representations. That is, as systems of concepts that collect objects in classes by virtue of their common properties perceived by subjects who simply observe and represent them in their minds. We have come a long way from our starting point where we looked at three ways classifications could be constructed. Take again the example of gender. Being male or female is seen to be a natural and obvious attribute of the body according to the scientific mode of classification. All we need to do is strip away our prejudices to see this properly. However, sociological models analyse gender classification according to the construction of sexuality in our society. Women are submissive, nurturing and supportive - ideal attributes for a mother. Men are assertive, intellectual, active - ideal attributes for a father. Gender is socially constructed by our roles in society, first as children, then as adults. Through 'structural exercises' ('Sit still, Jane'; 'Go out and play, Johnny') we acquire a 'socially (sexually) informed body'. Sometimes, this sociological model of classification is viewed as ideological, a set of practices and definitions that screen true gender identity. Thus, some feminists argue that woman's 'true' nature is no more submission and nurturing than is man's true nature. This is an ideological gloss imposed by men so that they can control women. The other version of the sociological model, exemplified by Foucault and Bourdieu, suggests that gender identification is a result of a whole series of practices and strategies that cannot be assessed for truth or falsehood. Rather, our sexuality is constructed and defined through these strategies.

As you can readily see, the grounds for classification and, therefore, the classes produced have real effects. The women's movement testifies to that in the case of gender. It is also the case for psychiatric practices as we have seen in our history of the emergence of psychiatric classification and its object, mental illness.

We have explored the shortcomings of the progressivist scientific and sociological ideological approaches. Finally, we have analysed the classification of mental illness as the result of three separate histories. The mentally ill first became separated from other inmates due to political pressure (from those who did not want to suffer contamination by association) and the economic redefinition of the poor as a pool of labour rather than non-labourers. This created a separate inhabited space. Secondly, there was a gradual individualising of the self. Thirdly, medical knowledge of mental disorders shifted from a generalised treatment of the body and mind, for example, through the humors and passions, to a moral psychology based on the ability of the mind and individual will to control these passions, to exercise self-discipline.

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There is a further aspect to this process that we will explore here - a denial of human agency. The scientific model talks of great minds uncovering prejudices to reveal truth. The sociological model talks of powerful groups imposing their will and definition of reality on others. Foucault's model sees power as an attribute of the system, something which constrains governor and governed alike. This idea will be unfamiliar to you. It differs from Berger's idea that society represses and controls us (Course HP03a, *Community and Identity*); and it is not the same as the Marxian notion that economic constraints subject individuals to economic functions (Courses HP05a, *Work in History* and HP05b *Work in Australia*). Foucault sees power as enabling, as part of the very process by which we recognise ourselves. Thus, the practices and classifications of psychiatry have come to define and make comprehensible our everyday lives.

The formation of the modern therapeutic apparatus has two general consequences for our understanding of psychiatric classification:

1. It means that although classification is inseparable from the network of social discipline, power is not necessarily seen as tied to repressive coercion or ideology but, on the contrary, is inseparable from the very techniques which define social agents as individuals.

2. As a result, the seemingly private forms in which individuals know their 'selves' are not clearly distinguishable from the public practices of social institutions.

Both these features of psychiatric knowledge are clearly visible in the phenomenon of the 'psychiatrisation' of conscience that permits individuals to recognise their own uncontrolled behaviour as a mental disorder requiring therapy, as the Los Angeles policeman did. In doing this, psychiatry cuts across the boundaries between power and knowledge and between institution and self. We can address both of these features as a means of anticipating work to come.

The relation between power and knowledge has come up at various points in our inquiries, for example, in Zilboorg and Henry's exemplary story of Pinel's liberation (i.e., re-classification) of the enchained lunatics of Bicetre. According to Zilboorg and Henry, the precondition for this liberation was that Daquin and Pinel should purify scientific observation of the social norms whose imposition had imprisoned the insane in error and superstition. In this view, power is an arbitrary imposition of social norms on scientific observation, distorting it and condemning its objects to darkness.

This relation was also at stake in Szasz's description of the 'myth' of mental illness and in Scull's history of

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its ideological imposition. For Scull, Tuke's humanitarianism and Pinel's liberation of the insane are not the result of a norm-free observation of mental illness. They are the outcome of the imposition of new norms and ideological images that condemn the deviant to medical imprisonment in the asylum. But, despite the revisions that Scull makes to their story of Pinel, he employs exactly the same model of the power-knowledge relation as Zilboorg and Henry. In Scull's view, the fact that the psychiatry of Tuke and Pinel involves the internalisation of norms of work discipline robs it of 'almost any real knowledge base'. Once again, power to establish and maintain a system of classification for different conducts (the power of the medical profession) is seen to transform knowledge into ideological misrepresentation. Power is only allowed the role of distortion and repression.

However, it can also be argued that, in asylum practice, power does not result in a misrepresentation of the self. Instead, it extends and focusses the disciplinary network in which the self is known and organised. Psychiatry is a disciplinary knowledge because it allows social discipline to take effect at the level at which the self is known and formed. We know ourselves due, in no small measure, to the practices and knowledges of psychiatry, developed both inside and outside asylums.

We cannot tell whether the disciplinary character of psychiatry makes it an exception in the domain of the social sciences at this stage of the programme. But it is clear, as suggested in the following quotation from Foucault, that psychiatry challenges the standard separation of knowledge and power. (The quotation is from a recent interview, where Foucault questions the idea that power represses knowledge and, in so doing, qualifies one aspect of his book *Madness and Civilization*.)

> When I wrote *Madness and Civilization*, I made at least implicit use of this notion of repression. I think indeed that I was positing the existence of a sort of living, voluble and anxious madness which the mechanisms of power and psychiatry were supposed to have come to repress and reduce to silence. But it seems to me now that the notion of repression is quite inadequate for capturing what is precisely the *productive* aspect of power. In defining the effects of power as repression ... one identifies power with a law which says no, power is taken above all as carrying the force of a prohibition. Now I believe that this is a wholly negative, narrow, skeletal conception of power, one which has been curiously widespread. If power were never anything but repressive, if it never did anything but say no, do you really think one would be brought to obey it? What makes power hold good, what makes it accepted, is simply the fact that it doesn't only weigh on us as a force that says no,

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> but that it traverses and produces things, it induces pleasure, forms knowledge, produces discourse. It needs to be considered as a productive network which runs through the whole social body, much more than as a negative instance whose function is repression. (Foucault in Gordon, 1980, pp.118-19)

In seeing power as that which produces rather than that which represses forms of personal identity, Foucault is effectively inviting us to contemplate a particular view - neither scientific nor sociological - of the history of psychiatric classification. His account, which has oriented our inquiry into the historical emergence of the psychiatric classification of mental illness, suggests three things.

1. Psychiatric practices involve social norms. But this in no way cancels out their medical or therapeutic character. Psychiatry emerged at precisely the point where techniques for the medical regulation of the moral self entered the world of disciplinary confinement, transforming it into the morally therapeutic environment of the asylum. The asylum is both moral (or social) and medical.

2. As a result, the psychological self cannot be systematically counterposed to asylum norms and practices. These provided the means by which such a self was classified separately from the bodily temperament and situated at the centre of all conducts and capacities as the principle of their medical regulation.

3. This does not mean that the psychological self is an ideological mask permitting the social control of personal identity. Just as psychiatry admits social discipline to the medical sphere, so too it transfers medical norms and practices to the social sphere. Norms of consistency of conduct, of emotional stability and self-restraint already have a medical character even when applied in other social institutions like the family. Hence, there is no question of the asylum simply 'translating' them into medical terms as a cover for a purely social discipline.

Of course, the discipline of psychiatry is a 'moral tactic' that builds social norms and practices into the moral environment of the asylum and makes cure depend on their internalisation as conscience. But psychiatry and its distinctive classification of certain behaviours as mental illness is also a 'medical tactic', in so far as it emerges with the migration of techniques like introspection and confession into the domain of medical regulation of the self. This is what permits psychiatric techniques to be relayed back into institutions like the family, the workplace and - as we saw in the case of the policeman - the

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institution of religion. Psychiatry, therefore, is not simply the point at which social discipline enters the domain of medical knowledge; it is also the point at which medical classifications of the self enter other social institutions, providing individuals with a means of recognising, understanding and disciplining their own conduct and demeanour.

We have spent much of the course investigating the example of how certain behaviour was reclassified from an undifferentiated and general category of madness or non-reason to the specific and modern Western category of mental illness. We have seen how this shift involved the establishment of a specific medical therapeutic institution, the asylum. In this sense, we have been able to refer, precisely, to the action of 'curing by classification'. With the establishment of the category 'mental illness', medical practice gained a new object of cure.

But it is worthwhile recognising that our concern with the history of mental illness has treated that history as an example of histories of classificatory practices. Our references to the work of a Tuke and a Pinel, or to the suffering and treatment of those we currently recognise as mentally ill, show that the issues of how certain classifications are established, maintained or altered are not purely abstract. On the contrary, classificatory practices are capable of producing concrete effects on social, political, economic and personal life, e.g. the incarceration and release of people.

In the following course, HP08b, *Disciplines*, attention shifts from the historical classification of behaviours to that of knowledges, in particular the division of knowledges into subjects or disciplines between which certain boundaries are established and maintained (or altered). In the next course, then, you will be concerned with classificatory practices that bear directly on the particular forms in which knowledge is organised in our society at the present time. You will again be invited to consider the possibility that practices of classification are far from being merely abstract or theoretical preoccupations. Indeed, in working through *Classifications* and *Disciplines*, you might come to consider them as key factors of institutional functioning.

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FURTHER READING

These readings are suggested for those who wish to explore some themes and issues further. They are not required for the assessment item.

Section 2

NEEDHAM, R. (1979). *Symbolic Classification*. Santa Monica: Goodyear.

A useful introduction to the anthropological approach to classification.

HIRST, P. & WOOLLEY, P. (1982). *Social Relations and Human Attributes*. London: Tavistock, chapter 2.

For a discussion of the social formation of human attributes that avoids competing biological and sociological reductionisms.

Section 3

DONNELLY, M.J. (1983). *Perceptions of Lunacy in Early Nineteenth-Century Britain*. London: Tavistock

A lucid historical description of the lunacy reform movement and the transition from eighteenth-century madness to nineteenth-century mental illness.

FOUCAULT, M. (1965). *Madness and Civilization*.

A difficult but rewarding description of what Foucault calls the 'archaeological' conditions permitting mental illness to appear as the object of psychiatric knowledge.

Section 4

RATHER, L.J. (1965). *Mind and Body in Eighteenth-Century Medicine*. London: Wellcome.

Contains the text of Jerome Gaub's *De Regimine Mentis* plus a full introduction and lengthy commentary on each section.

Section 5

ADLAM, D. & ROSE, N. (1981). 'The Politics of Psychiatry' in *Politics and Power*, No.4. London: Routledge and Kegan Paul, pp.165-202.

For further discussion of the political issues raised by psychiatry and the anti-psychiatry movement.

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ANSWERS TO SELF-ASSESSMENT QUESTIONS

SAQ 1 (p.17)

Because, according to Hempel, psychiatric diagnosis is a matter of observing groups of characteristics (symptoms) marked out by psychiatric concepts and then assigning the individuals possessing these characteristics to the classes and sub-classes of psychiatric classification.

SAQ 2 (p.20)

1.(a) Appearance

- excessively untidy hair and clothing
- chewed fingernails
- rigid facial expression.

(b) Response to interviews.

(c) Attitude towards others and toward self.

2. It should be fairly clear that these criteria are no less socially normative than the criteria for inadequate personality. The reason being that what is to count as a 'rigid facial expression' can only be judged against the norm - determining what we call a 'relaxed facial expression', and this norm is clearly relative to our social manners and customs. The same thing goes for judgements of good grooming, adequate responses to interviews and so on. Not only is there a notion of an idiosyncratic or individualistic interpretation of good grooming but also a socially defined and agreed upon interpretation, which will differ from culture to culture.

SAQ 3 (p.25)

Most of the points that Bourdieu makes are points both of language, meaning, symbol and of activity or practice (although, one should be careful not to rigidly separate these - language is practice and practice has its meaning). Thus, the woman represents darkness and does the tasks that relate to objects in the dark part of the house. Women are confined to the private, isolated, natural (i.e., bodily functions) world of the house. Men inhabit the public, social, cultural universe of the outside. The man who stays at home after daybreak is (loosely translated) 'hen-pecked'.

Some thoughts on Tutorial One

(a) Lions will not eat for three days after a good meal.

(b) Polybius, who was travelling in Africa with Scipio, is reported to have said that he saw lions crucified and hung up as a warning to other lions.

(c) Aristotle's account of the longevity of lions; the story and picture of Mentar the Syracusan.

(d) Demetrius's story of the panther (or leopard, the difference doesn't seem to matter) is interpreted as a lesson showing how kindness and mutual help may exist between creatures who are not formally obliged to each other in any way and have nothing to gain.

(e) Pliny treats the ways in which lions move their tails as 'marks or tokens' given to them by Nature (who has the role of an author) so that men can decipher their moods.

SAQ 4 (p.37)

During the eighteenth century, confinement was determined by legal categories that treated insanity primarily as a social incapacity (e.g. inability to manage one's estate) rather than as mental state. Thus the legal concept of *non compos mentis* was applied, possibly by laymen, not a doctor's definition and certificate.

SAQ 5 (p.38)

1. According to Donnelly, the separate confinement of the insane in asylums provided the institutional sites in which medical psychology found its object - mental illness. While, on the other hand, medical psychology provided an ideological justification for the new institutions of separate confinement.

2. Your summary should contain the majority of the following points:

   - that eighteenth-century madness was an affliction of both the mind and body;

   - that gradually madness was 'moralised' so that rather than remaining a fairly unavoidable disorder it became a sign of lack of moral resistance equated with guilt;

   - that as a result madness loses its bodily dimension and becomes a purely moral or psychological (i.e., non-physical) illness;

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- that the treatment of insanity changes accordingly, from the remedies of eighteenth-century medicine, which are simultaneously bodily and mental, to the psychological or moral management of conduct in a special morally directive environment that characterises the nineteenth-century asylum.

SAQ 6 (p.40)

1. Your list might include any of the following:

- cultural and historical tradition
- superstitious beliefs about the nature and origins of madness
- public opinion
- legal authority
- religious faith
- learned authorities
- sadism and other inhumanities
- philosophical speculations
- theological tradition
- lack of originality
- preconceptions
- linguistic conventions
- social norms and values.

According to Zilboorg and Henry, what these factors have in common is that they delay the inevitable medical recognition of mental illness by tying individual observation to various social and cultural norms, conventions and institutions. They are typically overcome by a great man who breaks with social conventions and norms through his individual observations and ideas.

SAQ 7 (p.41)

Stahl was 'very devout', 'morose', bitter', 'sharp of tongue'. He disregarded the tradition of his day, was 'convinced of being right'.

Daquin 'wants to learn', is humble and curious.

Pinel was 'modest and disinterested', was 'true to himself', was 'devout' although 'no recluse', 'a conservative man, warmhearted yet detached, elastic, adaptable, but courageous'. He was single-minded, sincere and intellectually honest, 'serene, moral, moderately pious', 'studious and learned' (and a few other wonderful things).

All were in some way separate from the ordinary events and views of their day - the devout but revolutionary Stahl, the inquisitive Daquin lacking in pre-conceptions, and Pinel whose distance from the stormy politics of the French Revolution allowed him to survive it.

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SAQ 8 (p.44)

Zilboorg and Henry portray the relation in such a way that the reform resulting in humane asylums is carried out despite the political struggles surrounding it, and as a pure effect of the wisdom and courage of individual scientists like Pinel. According to Donnelly, however, specialist asylums are primarily the outcome of a political struggle for social reforms waged by liberals and philanthropists. In his account, psychiatrists are presented with a new object of observation and classification by the political reform that segregates the mentally ill in special institutions. These special institutions, therefore, do not derive from the individual scientist's observation of mental illness as they do in Zilboorg and Henry's history. For Szasz, psychiatrists or classifiers of mental illness enter the service of the state.

SAQ 9 (p.45)

Scull distinguishes his approach from the 'history as progress' view (typified for us by Zilboorg and Henry) by rejecting the idea that the separate classification and confinement of the mentally ill was the result of progress in scientific knowledge and ethical understanding. Such a view he considers to be nothing more than a 'rhetoric of intentions', to be discarded in favour of an analysis of 'the actual facts about the establishment of and operation of the new apparatus for the social control of the mad'.

SAQ 10 (p.46)

According to Scull, the maturation of the 'capitalist market economy' provides the general historical precondition for the ruling class adoption of the strategy of institutionalising the deviant. In particular this event:

- broke down the old social relations of obligation and care modelled on and centred in the family, leaving the poor less willing and less able to care for their sick and insane, and leading to 'bourgeois dissatisfaction' with the old family-based system.

- established new norms of work discipline necessary for industrial labour which could only be imposed in institutions that gave the bourgeoisie complete control over the lives of labourers.

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SAQ 11 (p.48)

Insanity is a non-medical category for Scull because, unlike physical illness, it is not defined in terms of deviation from medical norms, but in terms of deviation from the purely social norms of work discipline imposed by industrial capitalism. As a result, the 'medical capture' of insanity that occurs when it is reclassified as mental illness does not have the character of a scientific discovery. Instead it appears as a misleading translation of a problem of social control into a medical framework.

SAQ 12 (p.48)

These causes are social rather than scientific. According to Scull, the character of moral treatment is governed by its attempts to secure the internalisation of disciplinary norms, which he pictures as a more effective means of enforcing work discipline than the old, directly coercive, means.

SAQ 13 (p.49)

For Scull, the moral treatment is non-medical because those it treats are not sick but deviant, and because it is not based in a specialist medical knowledge but in purely practical techniques of management. Moral treatment therefore obstructs the medical takeover of the asylum market because it does not provide the medical profession with a powerful and esoteric knowledge that it can use to drive out its competitors.

SAQ 14 (p.52)

1. The three stages isolated by Hirst and Woolley are:

   (a) The change in the concept of *persona* from that of social status carrying certain obligations to that of self-governing moral entity. This change occurring in Graeco-Roman antiquity.

   (b) The Christian transformation of the concept that occurs when the person is made independent of social statuses and is pictured as unified in the soul or spirit that makes the person the responsible agent of all its conduct.

   (c) The migration of the principle of self-governing agency from soul to mind or consciousness that occurs after the Reformation.

2. The Reformation develops a form of prayer as individual dialogue with God (as opposed to the collective prayer of the congregation). It is this individualising

technique that is associated with the rise of the individual conscience, or the self-conscious, introspective self.

SAQ 15 (p.53)

1. These norms include those of:

   - the unity of the self (i.e., of self-knowledge and self-direction);

   - true knowledge and perception (i.e., norms determining what counts as delusion and fantasy);

   - consistency of conduct (i.e., norms that will show up erratic behaviour as a fragmentation of the self).

2. Because forms of psychiatry with completely different theoretical bases (e.g. those of Pinel and Tuke) can still agree on the practices and institutional organisations that they deploy as a means of producing a self-monitoring, self-regulating person.

SAQ 16 (p.53)

The main difference is that in the Greek conception the sources of a social agent's spirituality, conduct and knowledge are not located in a single principle interior to the agent - the 'self' - but in an array of independent agencies and forces.

SAQ 17 (p.54)

Your list should include:

- techniques of introspection and self-analysis (cf. those given to Boy Scouts and Girl Guides as a means of evaluating their daily behaviour against a code of honour);

- techniques for assuming responsibility for conduct (e.g. confession);

- techniques for describing psychiatric symptoms (as opposed to having them deciphered);

- techniques of story-telling in relation to childhood experiences;

- techniques for 'free-association' of one word with another (used as a diagnostic technique in Western psychiatry).

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SAQ 18 (p.56/57)

1. Because Foucault's aim is not to tell the story of psychiatry in its own terms; that is, in terms of the gradual discovery of what we now call mental illness. Instead, he describes changes at the level of institutions and practices that provide the conditions under which the modern category of mental illness can emerge as the object of psychiatry. This level is compared with a deep geological stratum, and the actual history of psychiatry with a surface landscape. The metaphor of 'archaeology' is thus used to describe the process of uncovering the deeper level of institutions and practices that provides the history of ideas with its object.

2. (a) Changes in existing medical practice that gradually made it possible to treat madness as a pathology or illness with a specifically mental basis.

   (b) Changes in the institutions of confinement that isolated the insane from the larger confined population.

SAQ 19 (p.59)

1. The non-naturals are the elements of the individual's environment or regimen whose regularities and irregularities affect the body and mind. Amongst the non-naturals mentioned in these paragraphs are climate, food, exercise and occupation.

2. The target of this regulation is the unity formed by the individual's body and mind.

SAQ 20 (p.60)

By 'character' Gaub means that which governs correct behaviour and the fulfilling of social and familial obligations in particular. 'Character' differs from our idea of 'self' because it does not arise from conscience or consciousness. Instead, it is rooted in particular states of the body and mind that result from the dietary, climatic, etc. balance of the mode of life.

SAQ 21 (p.61)

For instance, Gaub suggests that the cause of anxiety is not the mind alone but rather due to bodily weakness. Canus Julius was able to resist anxiety at his encroaching death because of both bodily strength and a zeal for philosophy. However, Gaub insists that this resistance could have been overcome by 'thickened humors', i.e., by influencing the philosopher's bodily state.

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SAQ 22 (p.62)

Submersion therapy differs from modern psychological therapies because it aims to produce mental torment by arousing anxiety in the body, by 'stirring up', 'shaking', 'inwardly moving', etc. Hence it is not an attempt to affect behaviour or emotional state at one remove by modifying the psychological self - as is the case when modern psychiatry attempts to produce a psychological aversion to undesirable conduct through a regime of punishment and reward. Instead, Gaub's submersion therapy is aimed at transforming the mind directly in the body by immediately altering the emotional quality of the temperament.

SAQ 23 (p.64)

Their inability or unwillingness to labour.

SAQ 24 (p.65)

By being confined with the lepers, the newly-confined classes also became the objects of the horror and fear that had surrounded the leper houses.

SAQ 25 (p.65)

The demand to labour also has a religious basis. Work was believed to be a perpetual penance imposed on man after the Fall and idleness was therefore treated as a sin. Hence it must be understood that work at this time shares some of the characteristics of a religious observance.

SAQ 26 (p.65)

The first effect is that the mad are excluded from the social scene in which they had existed subject to varying degrees of tolerance and are hidden and silenced in the great houses of confinement.

The second effect is that because they are confined with the criminal, the immoral and the degenerate, the mad acquire the social and moral guilt of these groups. Madness thus acquires the dimension of moral transgression and guilt by virtue of this new boundary formed in social space. (We shall see below that the acquisition of this dimension is a crucial factor in the transition from madness to mental illness.)

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SAQ 27 (p.69)

1. Because music was held not just to affect the mind but to transfer its qualities to mind and body at the same time; for example, by causing the overly tense fibres linking mind and body to relax and assume the harmonious movement of musical vibrations.

2. The advent of moral or psychological treatments is signified when fear and joy are no longer used to transform the bodily qualities of the temperament but function as punishment and reward in a strategy aimed at producing self-restraint. Eighteenth-century therapies (like the 'cure by passion') are transformed into strategies of punishment only when madness is no longer treated as a disorder in the bodily economy - brought about by imbalances in the regimen - and begins to be treated in terms of a self, responsible for all its conduct and emotions. Only then could fear, for example, affect madness as a systematic punishment aimed at getting this self to regulate its own conduct and feelings.

SAQ 28 (p.70)

1. Foucault makes this remark because he sees the isolation of the insane as resulting from a combination of political and economic factors quite independently of any advances in medical knowledge. The main factors are:

   (a) The political campaign for the separation of criminals and paupers from madmen. This campaign is not based on sympathy for the mad that might lead to their liberation. Rather, it was based on sympathy for the criminals and paupers and assumed that whatever happened the mad would be left in confinement.

   (b) Changes in the economy and in economic doctrine freed the poor and idle from the moral exclusion of confinement and returned them to society to be maintained by welfare as an exploitable labour resource.

   Foucault argues that it is the combination of (a) and (b) that leads to the break-up of the old system of confinement and the isolation of the insane as its surviving remnant.

2. Towards the end of the eighteenth century, poverty and idleness cease being perceived as social and moral transgressions worthy of exclusion and confinement and begin to be perceived as economic phenomena related to the state of industry and the maintenance of a labouring population. Foucault locates this changed perception in

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the emergence of new social and economic conditions. With the emergence of an economy increasingly dependent on manufacturing industry it was necessary to maintain the poor in society as a reserve labour pool, rather than exclude them as moral delinquents.

SAQ 29 (p.74)

There are three main features common to Tuke and Pinel's transformation of confinement into the asylum. First, confinement in the asylum is given a new function: it is no longer simply a means of excluding a group from the social body and instead takes on the role of reconstructing the 'social consciences' of individuals who suffer from definite pathologies. Second, this reconstruction is achieved by new techniques of psychological management: the space of confinement is organised by moral laws and creates a corrective backdrop against which all the individual's deviations show up, leading to internalisation of the laws as self-restraint. Third, the doctor is given a new role. No longer merely a keeper tending to the physical ailments of the confined, the doctor is attributed special powers to know and cure the psychological afflictions of individual patients.

SAQ 30 (p.75)

1. Tuke says that it is not known whether the ultimate causes of mental illness are mental or physical. This does not bother him, however, because cures are achieved by treating the mental symptoms with 'techniques of management' and 'moral means'. For this reason he does not think that drugs are a very effective remedy and plans not to say much about them.

2. In Gaub, the object of 'anxiety therapy' is the temperament - an entity which is simultaneously bodily and mental - and Gaub's treatment arouses fear in the body. The object of Tuke's use of fear, however, is the patient's mind or psychological self. Likewise, the aim of inducing fear differs in each case. Gaub aims to modify the bodily temperament by directly transferring the physical qualities of the passion itself. Tuke on the other hand, aims to modify conduct by using fear to build up a principle of self-control, the patient's self.

SAQ 31 (p.76)

1. Your list might include:

(a) Occupational practices like gardening, sewing and studying, with their norms of regular work habits, consistent attention, application to a task, etc.

(b) Religious practices like bible reading, common worship and prayer, and hymn singing, with their norms of appropriate conduct, self-inspection and devotion to Christian ideals.

(c) Familial practices like the tea party, with its norms of correct table manners, and appropriate dress, conversation and conduct.

2. The tea party constitutes a technique of observation because it embodies the norms of etiquette, and appropriate dress, conduct and conversation through which the patients can observe their own conduct and demeanour as deviating or not. This technique of observation has a therapeutic or normalising function because the patients then 'vie with each other' in living up to these norms and thereby control their own behaviour and speech.

SAQ 32 (p.79)

1. The lesson is that this patient's high-born origins prevent him from acknowledging the authority of the governor which in turn obstructs his treatment. The fact that Pinel should leave us such a story in the form of a case history indicates that acceptance of the doctor's authority was a condition of successful management and therapy.

2. (a) Your list might include norms for:

- communicativeness
- emotional equilibrium
- coherence of speech
- regulation of body functions
- sense of personal identity
- consistency of conduct
- appropriateness of conduct
- performance of familial and social duties.

(b) The doctor's behaviour sets an example by his kindliness and consolation. The doctor initially gives the patients a space in which they are expected to exercise voluntary self-restraint. In the case of the ruined father, the governess takes on the role of showing him his actions through the governor's eyes.

SAQ 33 (p.80)

1. Your paraphrase of Pinel's character sketch of the governor should include most of the following features:

- he possesses humane principles and ideals

- he is absolutely attentive to the duties of his position
- he is blessed with unerring insight into life and the mysteries of the human heart
- he is unshrinking and brave
- he is physically strong and handsome
- his voice and demeanour are awe-inspiring.

2. Unlike Zilboorg and Henry, Pinel does not attribute his knowledge of insanity to his formal medical training, but to his practical association with the character of the governor. (In other words, in Pinel's character sketch of the governor we see the exemplary figure whose curative powers reside in the form of the doctor-patient relation made possible by the emergence of the asylum as a morally therapeutic environment. Pinel understands that his success with the insane depends on his practical ability to assume this exemplary mantle.)

SAQ 34 (p.81)

1. According to Foucault, the sources of the psychiatrist's curative power do not lie in medical knowledge but in the social and moral order. In particular the doctor embodies the familial and legal powers, those of father and judge.

2. The chief characteristics of this new medical personality are those of an almost magical knowledge of the moral self and power over it. These derive from the other 'social personalities' (the father, the judge, the confessor) whose mantles the doctor assumes in the morally charged environment of the asylum.

3. The resistance to paternal authority, the transgression of sexual norms, are both representations of the affliction and conditions for the cure. The chastisement and the confession allowed Pinel to observe these conditions and bring about the cure.

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